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TECHNICAL REPORT 4

An Evaluation of Community Health Workers' Scheme

—A COLLABORATIVE STUDY



राष्ट्रीय स्वास्थ्य एवं कुटुम्ब कल्याण संस्थान

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AN EVALUATION OF COMMUNITY HEALTH WORKERS' SCHEME A COLLABORATIVE STUDY

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PREFACE

This report is the outcome of collective effort on the evaluation of Community Health Workers' (C.H.W.) Scheme undertaken at the instance of the Government of India. It attempts to delineate several dimensions of the Scheme. These include its understanding, perception of its objectives and roles by officials concerned in its implementation at different levels. A study has been made of the processes that exist in different States in the selection of C.H.Ws. for the first batch; various kind of inputs brought into the Scheme, such as training, medicines and drugs, kit, honoraria and appointment of additional Medical Officer at the Primary Health Centre; the profile of selected C.H.W.; perception and attitude towards the Scheme as well as towards the selected C.H.Ws., of the community leaders, community members, Primary Health Centre staff and other non-health functionaries at the block and district levels. Based on the analysis of data collected and the processes adopted, inter-State variations, problems and bottlenecks encountered in the implementation of the Scheme identified. Specific recommendations have been made for taking corrective measures with regard to the Scheme.

Recognising that the Scheme had come into being barely nine months ago, it is premature to evaluate its performance and its impact on the health status of the population. Like-wise, it is too early to identify the population benefitted by this Scheme. In the absence of any monitoring system for concurrent evaluation and control of the Scheme, the results obtained in this study could be used only to fill such a gap. Further, as discussed in the report elsewhere, it would also be premature to judge the success or failure of the scheme at this stage even though there exists clear evidence towards the acceptability of the scheme by the public at large, the community leaders and other concerned health staff.

It is hoped that results obtained and recommendations made would be of some use for improving the implementation of the scheme so that it may able to move towards the anticipated direction of providing primary medical care services to the rural population based on the concept of community involvement and participation.

AUTHORS

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In the process of actual conduct of the study, a large number of officials and non-officials have helped immensely in various capacities. They are:

- a. Directors of Medical and Health Services of States/ Union territories;
- b. Officers Incharge of CHW Scheme at the State level;
- c. Deputy Directors/Assistant Directors concerned with the implementation of the scheme at the State level;
- d. Chief Medical Officers of the Districts and their Deputies where sampled PHCs are located;
- e. Medical Officers Incharge of the PHCs and their staff;

- f. Block Development Officers of the concerned Blocks and Presidents of Zila Parishads of the concerned districts.
- g. Village leaders, both formal and informal community members and village level workers.

They spared their valuable time on lengthy interviews and discussions with our staff on various aspects of the scheme. Many of them helped in providing accommodation, transport and other physical facilities to the field staff during data collection. But for the utmost cooperation extended by each one of them, timely conclusion of this study would not have been possible. The authors are, therefore, grateful to each one of them individually and collectively for the same.

A large number of faculty and research staff (see Appendix I) of the six participating institutions have worked untiringly, against all odds. The ungrudging support, sincerity and academic excellence demonstrated by each one of them deserve our gratitude. However, particular mention must be made of the contributions of Mrs. M. Kataria and Shri P.L. Trakroo, Assistant Professors in the Departments of Statistics and Demography; and Social Sciences respectively of NIHFV throughout the conduct of the study.

Last but not the least, we will be failing in our duty if, the excellent secretarial assistance offered by our staff (see Appendix I) is not duly placed on record. Despite the failure of machines and aching fingers, they have worked with devotion and the single motive of completing the task on time.

There may be many more who have helped in this effort but whose services have not been placed on record individually. The authors are deeply indebted to all of them for their services, in the field and in the offices of the different participating institutions.

AUTHORS

LIST OF ABBREVIATIONS

- | | | |
|-----|-------------------------|---|
| 1. | B.D.O. | Block Development Officer |
| 2. | MPW/UPW or
MPHW/UPHW | Multipurpose/Unipurpose Health Worker |
| 3. | P.H.C. | Primary Health Centre |
| 4. | B.E.E. | Block Extension Educator |
| 5. | L.H.V. | Lady Health Visitor |
| 6. | S.I. | Sanitary Inspector |
| 7. | H.I. | Health Inspector |
| 8. | V.L.W. | Village Level Worker |
| 9. | CHW | Community Health Worker |
| 10. | M.O. | Medical Officer |
| 11. | MPW-PHC | Primary Health Centre where Multipurpose
Workers Scheme is in operation. |
| 12. | Non-MPW-PHC | Primary Health Centre where Multipurpose
Workers Scheme is not in operation. |
| 13. | C.T.I. | Central Training Institute. |
| 14. | HFPTC | Health and Family Planning Training
Centre |
| 15. | A.P. | Andhra Pradesh |
| 16. | H.P. | Himachal Pradesh |
| 17. | M.P. | Madhya Pradesh |
| 18. | U.P. | Uttar Pradesh |
| 19. | U.T. | Union Territory |

CHAPTER 1

INTRODUCTION

Rural health care has been a perpetual problem in India. In an effort to ameliorate the same, a vast network of Primary Health Centres (PHCs) has been set up in the country for providing comprehensive health care services to the rural population as per the recommendations of the Bhore Committee¹. We have, today, about 5,372 PHCs and 37,775 sub-centres. These however, have not made significant impact on the health status of the rural population. There continues to exist large unmet felt need for health services in rural areas. In this context, the Multipurpose Workers Committee (1973)², while examining the health needs of rural community and acceptability of health workers, recommended training and functioning of multipurpose health workers, so as to increase the accessibility of care and increased population coverage by health services. The Committee on Medical Education and Support Manpower, popularly called Srivastava Committee (1975)³, further deliberated and provided some broad guidelines for a health services strategy in India.

While making recommendations, the Srivastava Committee suggested, *inter alia*, a viable and economic model of health services hinging on a need-based intermediate technology.

1. Report of the Health Survey and Development Committee, Vol. I, II, III and IV, 1946. Manager of Publications, Delhi.
2. Report of the Committee on Multipurpose Workers under Health and Family Planning Programme, 1977 (Mimeographed). Ministry of Health and Family Planning, New Delhi.
3. Health Services and Medical Education; A Programme for immediate action, Report of the group on Medical Education and Support Manpower, 1975. Ministry of Health and Family Planning, New Delhi, India.

The need for self education of every individual in the community on health matters in terms of body mechanism, its functions, and maintenance, etc.; was recognised. The community's responsibility for safeguarding its own health was specified in terms of supply of safe drinking water, disposal of human excreta, avoidance of air-pollution, and control of communicable diseases. What is, perhaps, more important is the total recognition of the multi-sectorial nature of health, depending as it does on economic well-being, health and nutrition education and other non-health inputs. Towards the fulfilment of this objective, the Srivastava Committee recommended the creation of large groups of part-time semi-professional workers, selected from among the community itself, who would be close to the people, live with them, provide preventive and promotive health services including family planning, in addition to looking after common ailments. These are essentially self-employed people and, therefore, do not form a part of Government bureaucracy. Among the several categories of people available in villages and willing to undertake health tasks, the Committee identified primary school teachers, house-wives, practitioners of indigenous systems of medicine, *dais*, as the more feasible ones.

The Rural Health Scheme recently announced by the Ministry of Health and Family Welfare, Government of India, to strengthen health care services in rural areas is an extension of the above concept. "The purpose behind the scheme is to provide adequate health care to the rural people and, at the same time to educate them in matters of preventive and promotive health". The aim is to provide "simple medical aid within the reach of every citizen by organising a cadre of medical and para-medical community health workers, of whom the trained practitioners of indigenous systems of medicine will be a part". The scheme provides that every village or community with a population of 1,000 has to select one representative who is willing to serve the community and enjoys its confidence. The person will then be given a three months' training in simple basic health services. It further provides that the person would preferably be below 30 years of age, must be literate and be able to read and write well and most preferably have a formal education of at least upto sixth standard. It would be even

*Guidelines for the Training of Community Health Workers issued by the Ministry of Health and Family Welfare, New Delhi.

better if the community selects a person who is already practising one of the systems of medicine or is educated upto 10th standard. The community will be responsible for supervising the work of this community health worker called the "Swasthya Rakshak". The responsibility of the Government is limited to provide training and technical guidance. After training, the community health worker will be given a kit consisting of common medicines for simple ailments, including those from indigenous systems of medicine. They are not envisaged as full time health workers and it is expected that they would perform community health work in their spare time for about 2-3 hours daily. During the period of training, the trainees will receive Rs.200/- per month as stipend for three months and a simple medicine kit. Once they commence work, they will get an honorarium of Rs.50/- per month for working with the community and Rs.600/- worth of medicines per year. The task expected of the community health worker is immunisation of the new born and young children, distribution of nutritional supplements, treatment of malaria and collection of blood samples. He is, however, also expected to look after elementary curative needs of the community. The overall philosophy is that the health work which has hitherto been looked after largely by Government, will now, for the first time, also rests in the hands of the people. The community health worker being the man of the community, will be accountable to the community and the community, in turn, will supervise his work. The philosophy of community involvement and participation in the provision of primary health services, also implies that the community would supplement the resources required for the continuation of this work and would completely take over the programme at a subsequent point of time.

(The scheme was introduced on 2nd October, 1977] in all PHCs of 28 districts of the country where re-orientation of unipurpose workers as multipurpose workers was completed, and in one PHC each from the remaining districts of the country. The total number of PHCs covered by the scheme under the first phase is 741. The scheme has been accepted by all the States and Union Territories (except J&K, Karnataka, Tamil Nadu and Kerala). The training of the first batch of community health workers was completed on December 31, 1977.

The draft community health workers' scheme evoked wide public interest. Whereas no one doubts the sincerity of the

Government in providing health care to the rural masses, the programme has come in for adverse criticism on grounds of inadequate preparation. The medical profession, in addition, has charged the scheme for promoting quackery. An important criticism is lack of pilot studies on feasibility of the scheme particularly in the light of heavy investment of public funds required for its implementation. However, there are a number of basic questions behind the scheme:- What is the scope of primary health care? Is it ever possible to use non-health workers picked up from the community for delivering selective components of health care to the rural community? Does such an information make any meaningful alteration in the health status of the people? Is this approach practical? Is it feasible? Is it acceptable to the community?

It is necessary to understand that provision of primary health care to the rural population by voluntary health workers is not without scientific foundation. A large number of countries all over the world have extensively employed bands of trained voluntary workers for this purpose with great success. Even, in India, information on voluntary health workers in health care is available from over 60 experiments on alternative strategies for delivery of health care being conducted in different parts of the country*. It is true that these experiments present wide variations on a number of dimensions. Despite these variations they do, however, lend themselves to conclusions, some of which have direct relevance to the CHW Scheme. These projects have proved beyond doubt the potential of non-health workers in the delivery of primary health care to the rural communities. In most cases they were found to be popular and acceptable to communities. Most of the instances show fairly impressive results in terms of reduction in infant mortality or increased acceptability of family planning or reduction in nutritional disorders. Despite all this, the need for systematic evaluation of community health workers scheme by independent agencies is recognised, particularly because of absence of any system for its monitoring and control.

*Rao, K.G. 'Alternative strategies for delivery of health care - A review of experiments in India and outside'.
(Unpublished manuscript 1978)

In December, 1977 Government of India asked the National Institute of Health and Family Welfare to carry out an evaluative study of this scheme on a national scale in collaboration with such other independent organisations who were willing to undertake the same. At the first meeting of the participating institutions held in Delhi on December 29, 1977 it was generally agreed that a comprehensive evaluation of the scheme would not be feasible so early after its implementation. It was realised that the training programme of the first batch of Community Health Workers at the PHC's would have been barely finished by the time data collection began. Further, it was noted that the objectives of the scheme were not clearly defined in specific and measurable terms. If the intention was to evaluate the performance of the CHW, this could not be possible within 1-2 months of their being in the field. Moreover, the scheme did not envisage CHW to maintain any records. Any impression of his effectiveness as such could be obtained only from indirect sources such as Government health workers, community leaders and a cross-section of population from the villages, where he is working.

Under the circumstances, the objectives of the scheme were derived from the various governmental documents which are as under:

- a. to provide cent per cent coverage of the rural population of the country with the type of services envisaged to be provided by the CHW, over a period of 2 years;
- b. to ensure community participation for the purpose of:
 - i. administrative supervision of the CHW;
 - ii. ultimate take over of the scheme by the community; and
 - iii. to improve the utilisation of health services provided by the PHC Complex thereby leading to increased satisfaction of the community.

The purpose of the evaluation as understood by us are:

- a. to determine the organisational feasibility and

acceptability of the scheme by the people, so as to enable the authorities to decide for expansion or otherwise of CHW scheme in its present form or with certain modifications;

- b. to collect necessary information from the State Governments in, so far as, operational aspects of the scheme are concerned so that necessary improvements could be made in the future.

Inspite of the above stated limitations, the present evaluation is designed to cover several dimensions of the scheme as given below:

- a. perception and the extent of understanding of the objectives of the scheme and the roles and responsibilities of the community health workers;
- b. the process of selection of community health workers including community participation and their involvement;
- c. profile of community health workers;
- d. training of community health workers including its duration, content and effectiveness;
- e. administration and management of the scheme including inputs and logistics, such as manuals, honoraria, supply of medicines, kits, etc.;
- f. performance of the community health workers;
- g. attitude towards and perception of the scheme by the community;
- h. acceptability of the scheme and the selected community health workers; and
- i. feasibility of scheme.

Thus, this evaluation examines the implementation of the scheme on all these dimensions as obtained in different States and Union Territories. It attempts to bring out inter-State variations that exist, and highlight the problems

and difficulties in the implementation of the scheme. An attempt has also been made to make specific recommendations for strengthening the scheme.

However, it may be noted that though the performance of CHW is also being assessed, it would be only elementary for reasons discussed earlier. Further, this evaluation does not look at the population coverage by CHWs or the population benefitted by their services. A study of these aspects must necessarily await some reasonably long time so that the scheme is able to get off the ground.

CHAPTER II

METHODOLOGY

The development of methodology for this evaluative study was influenced to a considerable degree by a number of factors. These were: the purpose and the scope of evaluation, its collaborative nature, time constraint involved in conducting a nation-wide study, and the desirability of preparing a report, highlighting, among others, important inter-State variations. Various aspects of the methodology concerning the present effort were broadly classified as follows:

1. identification of levels of administrative set-up;
2. identification of functional areas of study;
3. sources of data;
4. development of instruments;
5. sample size and design;
6. methodology for collection of data; and
7. analysis and interpretation of data.

Identification of levels of administrative set-up

Keeping in view the overall objectives of the scheme and the operational details evolved for its implementation, collecting and utilising information from sectors other than health also, especially at the grass-root level, was considered desirable. Therefore, the levels of administrative set-up from where the information was to be generated were decided as follows:

1. (i) *Organised health services set-up*

- (a) State level concerned with policy planning.
- (b) District level concerned with formulation of operational details of scheme.
- (c) Primary health centre complex concerned with implementation of scheme at grass-root level.

(ii) *Link between organised health services and community*

Community health worker.

(iii) *Beneficiaries or consumers and their representatives*

- (a) Village level
 - Community members
 - Community leaders
 - Village level workers
- (b) Block level
 - B.D.Os.
- (c) District level
 - Zila Parishad President/ Members

2. *Identification of functional areas of study*

The functional areas or dimensions of the scheme on which the evaluative study has been based are given below. These were worked out taking into consideration the status of implementation of the scheme at the time of conducting the study and in keeping with the objectives and scope of evaluation.

- (i) Points and the extent of deviation of the scheme actually being implemented in different States from those specified by Government of India, Ministry of Health and Family Welfare;
- (ii) performance of community health workers in each of the activities assigned to him/her;
- (iii) attitude and commitment of community health workers to health work;

- (iv) attitude and perception of community leaders, *dais*, rural health workers and doctors towards the scheme in general and CHWs of their respective areas in particular;
- (v) adequacy and appropriateness of medicines and drugs supplied to the CHW;
- (vi) various methods and techniques employed by CHWs in carrying out their health activities;
- (vii) effect of health work on the normal vocations of community health workers;
- (viii) extent of cooperation and guidance extended by Primary Health Centres in the work of CHW such as:
 - (a) technical guidance;
 - (b) disbursement of medicines, drugs etc.; and
 - (c) referral of cases etc.
- (ix) effect of the work of community health worker on the performance of PHCs;
- (x) problems, bottlenecks in the effective functioning of CHW (including use/abuse of the inputs by CHW, community leaders and such others);
- (xi) effectiveness of training;
- (xii) administrative and logistics aspects at each of State, District and PHC levels.

The functional areas were decided with a view to cover all the dimensions providing thereby the factual attitudinal assessment of the implementors of the scheme and the potential beneficiaries. These were to serve as guiding principles on the basis of which instruments for data collection were developed, conclusions drawn and interpreted.

Sources of data

The study involved collection of primary data from respondents at various levels of the health administrative set-up, as well as from the community members and leaders. Data

was also collected from secondary sources such as instructions and circulars issued at different points of time from Central and State Governments and records of district and PHC levels.

The categories of personnel who were chosen on the basis of extent of their involvement in the planning or implementation stages of CHW scheme directly or indirectly, the number of respondents in each category and the total number interviewed are as follows:

Level of administrative set-up	Category of respondents	Number for each category	Total No. of respondents
State	Director of Health Services	1	
	Officer-in-Charge of CHW Scheme	1	
	Officer-in-Charge Planning and Evaluation	1	
	One of the Programme Officer	1	
	Regional Director (if any)	1	60
District	Chief Medical Officer	1	
	Deputy Chief Medical Officer-in-Charge CHW Scheme	1	
	One of the Programme Officers (Malaria Officer or District Family Planning/Welfare Officer)	1	
	President/Member of Zila Parishad	1	142
Block P.H.C.	B.D.O.	1	73
	M.O. Incharge PHC	1]	
	M.O. Incharge Training of CHW	1]	
	The Third Medical Officer at PHC, if any	1]	142
	Block Extension Educator	1]	
	Sanitary Inspector	1]	227
Village	Lady Health Visitor	1]	
	Community Health Worker per PHC	4	299
	Community Member per CHW	20	6013
	Community Leader (formal) per CHW	1]	

Community Leader (informal)]	604
per CHW	1]	
Multipurpose Health Worker/ Unipurpose Health Worker		
per CHW	1	225
Village Level Worker per CHW	1	203

Development of instruments

After having identified the functional areas mentioned earlier, an inventory of items under each area was developed. It provided an exhaustive and overlapping information on areas under investigation. Since the categories of persons to be interviewed were already defined, the inventory of items was re-arranged into different schedules meant for collection of information from different categories of respondents. The deciding factor for the exhaustiveness of the information asked for was the extent of involvement of a particular category of respondent with the scheme. In all, 14 such schedules (13 for various respondents indicated under 3 above plus one for collection of data from PHC records) were developed. A number of areas were common to some schedules. These were introduced deliberately to obtain information from different respondents on the same dimensions of the scheme for the purposes of cross-checking and validation of data.

The schedules contained structured, unstructured and multiple choice items attempting to cover knowledge, attitude and reaction of different levels of respondents.

All these schedules (except District and State level) were pre-tested by each of the participating institution in one Primary Health Centre in their area to ascertain the content validity of the questions asked. The detailed report of these pre-tests made it possible to introduce necessary improvements in the content and format of the schedules.

The District and State level schedules were in the form of open-ended interviews and were administered by Senior Officers in the form of open-ended interviews.

Sample size and design

In view of the large quantum of information to be collected at different levels of administrative set-up, within the constraints of time and resources, it was not feasible to cover the entire universe of respondents. Hence, sampling was resorted to and the size of the sample was determined more on the basis of practical considerations of time, resources and logistics, rather than on the basis of rigorous statistical requirements.

Further, it was decided to cover all States and Union Territories, implementing this scheme, except Union Territories of Dadar & Nagar Haveli and Andaman & Nicobar Islands, which were away from mainland and would have posed tremendous problems in data collection. It may be mentioned that in the States of Tamil Nadu, Kerala, Karnataka and Jammu & Kashmir, the scheme was not implemented and hence were not covered in the present study.

With regard to the coverage of districts and primary health centres in each of the States and Union Territories, stratification according to MPW and non-MPW PHCs was done. This was undertaken on account of interface/crucial linkages expected under the scheme between most peripheral health workers of the organised health services *i.e.* multipurpose or unipurpose workers and community health worker. The sampling fraction of primary health centres adopted was 10 per cent of the total number of 777 PHCs, where the scheme was launched on October 2, 1977, with the provision that a minimum of one primary health centre in each State/Union Territory would be included in the sample. This worked out to a total number of 78 primary health centres to be studied. This number was allocated to different States, and within each State to MPW/UPW PHCs by proportionate allocation. The actual selection from each stratum was based on randomisation.

It was, however, found that there were some PHCs where certain evaluative studies by Demographic Research Centres were in progress. Such PHCs were suitably substituted by other PHCs drawn at random. The final list of PHCs included in the sample from various States and Union Territories is given at Appendix - II(a).

In case of administrative set-up at primary health cen-

tre, district and State levels, there was no need for taking a sample of respondents. However, in case of community health workers selected in the first batch were sampled from health workers, about 20 per cent of the community health workers selected in the first batch were sampled from each PHC. This resulted in an average of four CHWs per primary health centre, who were selected at random. After the selection of CHWs, only those Multipurpose/Unipurpose Workers and VLWs working in CHW scheme areas were included in the study.

In order to identify community members, a ten per cent sample of total number of families (on the assumption of about 200 families per 1000 population) was chosen at random wherever household list was available. In case such list was not available, a systematic sample starting from the left side of the village was drawn, as was done in the National Malaria Eradication Programme.

Two community leaders, one formal and one informal, from each of the villages of sample CHWs were selected. Whereas the formal leader was defined as one occupying a formal position in the village social system such as Sarpanch or Member of the Panchayat, the informal leader was one who is not occupying such a position but considered to be influential by the local people. The choice of such a person was left to the field team to identify him based on interviews with the community members.

Methodology for collection of data

After the preparation of instruments defining the sample design and its size, it was considered necessary to provide an opportunity to the field investigators to know about the purpose and the methodology of this evaluative study. A comprehensive orientation training alongwith manuals and other items required for data collection including the preparation of tour diary etc., was undertaken by each of the participating institutions.

For the purpose of collection of data at district, PHC and village levels, various teams each consisting of four research investigators and headed by a faculty member/ Research Officer/Assistant Research Officer, were constituted. Based on the experience of a similar study carried out earlier and the pre-test report, it was estimated that

one team would be able to collect data in a PHC unit consisting of villages, PHC and district headquarter in about a week's time (including travelling). Senior Officers of the rank of Professor/Deputy Director or equivalent of the participating institutions undertook the task of collection of data at State level. Collection of data at various levels of administrative set-up was undertaken in March, April and May, 1978.

In the course of actual collection of data, this methodology had, however, to be slightly modified at some places in view of various factors, such as, geographical location, terrain, means of communication and language, which also necessitated the use of interpreters in certain areas. To facilitate the data collection process, in some situations, translation of schedules into regional languages was undertaken. The insistence on scrutiny of schedules in the field by the team leaders ensured the quality of data to a great extent. However, from the logistic point of view, data collection workload was divided among the participating institutions regionwise, according to the location of institutions. In the case of Uttar Pradesh, most of the workload was undertaken by Indian Institute of Management, Ahmedabad, in view of the special circumstances of its involvement in India Population Project, Lucknow (see Appendix - II(b)).

Data from Arunachal Pradesh and Nagaland could not be collected despite repeated attempts. Therefore, the total number of PHC studied was 76 instead of 78 as described earlier. Non-response was, however, negligible even when it existed, it was either on account of personnel being on long leave or posts lying vacant for quite sometime. Wherever anyone of the above mentioned categories of respondents was not in position, information was collected from a relevant person with different designation but holding an equivalent position in relation to the CHW scheme. As far as community members were concerned, the interviewers had been instructed to choose an alternative house utilising random numbers or the next household as a systematic sample, if a particular house falling in the initial sample was found to be locked.

The difficulties faced by investigators in collection of data were negligible as excellent cooperation was exten-

ded by authorities at all levels of administrative set-up, which made the field work pleasant and productive.

Analysis and interpretation of data

After the finalisation of schedules and soon after the data collection started, efforts were made to develop the coding, tabulation plans and format of the report almost concurrently. The problems of translation of responses to open-ended questions in regional languages into English were taken care of by utilising internal resources of NIHFV and engaging a technical person for this purpose.

As the data pertaining to State and district levels was essentially qualitative in nature, it was analysed manually, while the rest of the information was analysed on Tabulators/Computers.

In general, the mechanism adopted throughout the period of study was that the responsibility for developing instruments, work schedules and preparing initial documents was given to one or more institutions and the same was discussed and finalised in a joint meeting. In all six meetings (on 29th December, 1977; 24th and 25th January, 1978; 20th and 21st February, 1978; 1st and 2nd May, 1978; 29th May to 3rd June, 1978; and 27th June, 1978) were held for the purpose of planning and conducting the study, writing and finalising the report.

CHAPTER III

PERCEPTION OF OBJECTIVES, ROLES AND RESPONSIBILITIES

Objectives

The Government's new 'Health Policy' based on the election manifesto of Janata Party indicate the objectives in broad terms as given below:

"It has been realised that the health status of the rural population can be improved not merely by increasing the number of doctors or increasing the output of medicines, but by making each individual realise and appreciate the need of simple steps in sanitation, preventive, promotive and rehabilitative health activities. The Government's new 'Health Policy' aims at providing adequate medical care where such care is needed and educate the people in the matter of preventive and promotive health."

The intention of the Government is that every individual should himself be conscious of taking care of his own health needs. The role of Community Health Workers as a link between community and organized health service facilities and as a 'change agent' to bring about this realization in the community is clear not only from the statement given above but from a number of deliberations on this topic since the launching of the scheme.

An analysis of various official documents brought out by the Union Ministry of Health from time to time, since the launching of the scheme, shows that the objectives of the scheme have been defined only in broad terms, such as providing medical care where such care is needed and educating the people in preventive and promotive aspects of health.

Such a broad definition of objectives only makes the task of evaluation of the scheme difficult besides leaving to a

number of ambiguities in the perception of objectives of the scheme, roles and responsibilities of community health worker and other personnel concerned with the implementation of the scheme. With a view to ascertain as to how the officials at State, district and PHC levels perceived the objectives of the scheme, a question was asked as to what in their opinion were the objectives of the scheme. The responses are presented in Table 1.

Most frequently mentioned objective was to provide treatment of minor ailments. However, medical officers of PHCs perceived health education, promoting sanitation and preventing diseases as more important objectives.

The responses of State and district level officials are clustered around the objectives of providing treatment of minor ailments, health education and creating a link between community and PHC; while the responses of medical officers and other supervisors in the PHCs are more spread out indicating a mix of curative, preventive and promotive roles of community health worker. This might be due to lack of interest or apathy to the scheme, particularly at the State level, as was indicated during interviews of State level officials; some of whom responded in the following manner:

"We are Government servants and hence have to do, whatever we are asked to do. But, if you ask about our honest opinion, then we do not agree with the scheme... .." ".....whatever order comes from the top, we send it down below for implementation.....".

Roles

The roles of health personnel are closely related to the objectives of the scheme. These must be properly understood by all concerned personnel in the light of objectives. If, there is any inconsistency in the roles of the personnel as defined or understood then it will indicate existence of a problem which may, at some stage, seriously affect the outcome of the scheme. Therefore, an attempt was made to elicit from the respondents about the roles of the health personnel at PHC level *i.e.* Medical Officer and Supervisor (BEE/LHV/HI/SI) and MPW/UPW in CHW Scheme to see what kinds of inconsistencies exist, if any.

TABLE 1

OBJECTIVES OF THE SCHEME AS STATED BY THE
STATE, DISTRICT AND PHC LEVEL OFFICIALS

Objectives	Officials		PHC	
	State level	Dist. level	Medical Officers*	Other Supervisors**
1. Treatment of minor ailments	17(28.3)	41(28.9)	49(34.5)	92(40.5)
2. Health Education	17(28.3)	29(20.4)	73(51.4)	71(31.3)
3. Immunization at door-step	3(5.0)	5(3.5)	13(9.2)	22(9.7)
4. Sanitation and preventive diseases	6(10.0)	16(11.3)	70(49.3)	67(29.5)
5. Nutrition education	0(0.0)	2(1.4)	3(2.1)	3(1.3)
6. Family Planning education and motivation	2(3.3)	8(5.6)	24(16.9)	17(7.5)
7. Vital registration promotion	0(0.0)	3(2.1)	20(14.0)	2(0.9)
8. Link between Community and PHC	16(26.7)	17(12.0)	33(23.2)	36(15.9)
9. Health facilities at door-step	9(15.0)	34(23.9)	45(31.7)	98(43.2)
10. Unknown	4(6.7)	2(1.4)	6(4.2)	12(5.3)
Total	60	142	142	227

The figures in brackets indicate percentage of officials who mentioned that objective.

* Includes both MO Incharge and MO Incharge of CHW Scheme.

** Include BEE, LHV, SI and HI.

Officials at State, district and PHC levels were asked to state the roles of these personnel as they saw them. Later, they were asked to select three important statements from the given statements (Appendix IIIa) which described their roles appropriately. The responses to open-ended and multiple choice questions are presented in Tables 2, 3 and 4. Table 2 shows that almost all categories of officers perceived imparting training to CHWs as the most important role of medical officers. Further, the responses to open-ended as well as multiple choice questions for most of the category of officers clustered around the roles of (a) imparting training (b) selection of proper candidates, and (c) sorting out difficulties of CHWs. An interesting finding, however, is the spread out of responses to multiple choice questions *vis-a-vis* open-ended questions, in respect of all categories of officers interviewed. This indicates that the respondent perhaps became aware of many more roles of PHC staff from the list presented to them. In fact, some of the officials commented that the list of roles as provided to them had improved their understanding of the scheme.

As far as the roles of supervisors are concerned, imparting training, ensuring that the field workers contact the CHW and work in harmony, supervising and evaluating CHW's work appeared to be more important objectives, as can be seen from Table 3.

The responses with regard to the role of multipurpose/unipurpose workers as given in Table 4 show a greater scatter when compared with the responses recorded in Tables 2 and 3. It indicates a greater degree of lack of clear understanding of roles of the most peripheral health workers of PHC. In Tables 3 and 4 for supervisors and multipurpose/unipurpose health worker's roles respectively, the responses to multiple choice questions are more scattered as compared to the open-ended questions. Further, no significant trend was observed in the responses of State, district and PHC level officials about the roles of PHC officials.

The responses of peripheral health workers (MPW/UPHW) to open-ended and multiple choice questions are given in Table 5. At first, the multipurpose/unipurpose health workers, by and large perceived themselves as a supervisor and guide of CHW. However, they became aware of their various roles in the scheme as shown by scatter of responses to multiple

TABLE 2

PERCENTAGE DISTRIBUTION OF STATE, DISTRICT
AND PHC LEVEL OFFICIALS AND SUPERVISORS BY
ROLES OF MEDICAL OFFICERS

Role	State N=60		District N=142		PHC			
					Medical Officers N=142		Other supervisors N=227	
	A	B	A	B	A	B	A	B
1. Imparting training to CHWs	I (96.7)	I (86.7)	I (72.5)	I (83.1)	I (90.1)	I (65.5)	II (87.7)	I (54.6)
2. Selection of proper candidates		II (40.0)	III (31.0)	II (42.3)	II (82.4)	II (52.1)	I (87.7)	
3. Sorting out ordinary difficulties of CHWs	II (83.3)		II (42.3)		III (69.0)		III (46.8)	
4. Supervising and evaluating work of CHWs	III (58.3)							
5. Treating the case referred by CHW		III (38.3)						
6. Informing the community of correct nature of scheme				III (40.8)				
7. Ensuring proper use of medicine by CHW						III (35.2)		II (43.6)

A - Response to open-ended questions.

B - Response to multiple choice questions.

Figures in Roman indicate the rank ordering of roles.

TABLE 3

PERCENTAGE DISTRIBUTION OF STATE, DISTRICT
AND PHC LEVEL OFFICIALS AND SUPERVISORS BY
ROLES OF SUPERVISORS

Role	PHC							
	State N=60		District N=142		Medical Officers N=142		Other supervisors N=227	
	A	B	A	B	A	B	A	B
1. Imparting initial training	III (40.0)	I (60.0)	II (21.8)	I (62.0)	I (75.4)	I (64.1)	I (68.7)	I (54.6)
2. Ensuring that field workers contact the CHW and work in harmony		III (50.0)	III (17.6)	II (54.2)		II (57.0)		II (48.0)
3. Supervising and evaluating the CHW's work		II (59.7)		III (47.2)	II (73.2)	III (56.3)	II (61.7)	III (46.7)
4. Keeping liaison with the village leader	II (53.3)							
5. Solving the difficulties of CHW	I (93.3)		I (79.6)					
6. Participating in selection of CHW					III (45.8)		III (39.6)	

A - Response to open-ended questions.

B - Response to multiple choice questions.

Figures in Roman indicate the rank ordering of roles.

TABLE 4

PERCENTAGE DISTRIBUTION OF STATE, DISTRICT AND
PHC LEVEL OFFICIALS AND SUPERVISORS BY ROLES
OF MULTIPURPOSE/UNIPURPOSE HEALTH WORKERS

Roles	State		District		PHC			
	N=60		N=142		Medical Officers		Other supervisors	
	A	B	A	B	A	B	A	B
1. Keeping liaison with the CHW	I (55.0)	I (95.0)	III (29.6)	I (78.9)		II (73.2)	I (49.3)	II (69.2)
2. Giving immunization to children identified by the CHW	II (33.3)	II (76.7)		II (73.9)		I (75.4)		I (74.9)
3. Helping him to build PHC's image in the community		III (43.3)		III (66.9)		III (50.7)		III (47.1)
4. Supervising the work of CHW	III (40.0)		II (32.4)		I (65.5)		II (40.1)	
5. Helping CHW in maintaining records			I (47.9)					
6. Sorting out difficulties and guide him					II (23.9)		III (19.4)	
7. No role in training of CHW.					III (19.7)			

A - Response to open-ended questions.

B - Response to multiple choice questions.

Figures in Roman indicate the rank ordering of roles.

choice questions, where 'helping in building the image of PHC', 'liaison work with CHW', 'giving immunizations to children referred by CHW' were perceived to be the more important roles.

TABLE 5

PERCENTAGE DISTRIBUTION OF MULTIPURPOSE/UNIPURPOSE
HEALTH WORKERS BY THEIR OWN ROLES

Roles of the Multipurpose/ Unipurpose Health Workers	MPW/UPW (N = 225)	
	A	B
1. Helping, supervising and evaluating CHW's work	I (31.6)	I (65.5)
2. Helping CHW in maintaining records	II (23.6)	
3. Keeping liaison with CHW	III (20.0)	II (69.3)
4. Giving immunization to children identified by CHW		I (76.9)
5. Helping CHW to build image of PHC		III (60.4)

A - Response to open-ended questions.

B - Response to multiple choice questions.

Figures in Roman indicate the rank ordering of roles.

Responsibilities

The Community Health Worker has to undertake a number of responsibilities in order to do full justice to the various roles expected of him. A clear-cut understanding of res-

possibilities by the Community Health Workers, health personnel at various levels of administrative set-up, consumers and the representatives of people is essential. Towards this end, the respondents were asked to name three most important responsibilities of Community Health Workers. Their responses are given in Tables 6 and 7.

It can be observed that all respondents, except BDOs and medical officers, perceived 'treatment of minor ailments' as the most important responsibility of CHW. The BDOs and medical officers viewed 'providing first aid in emergencies' and 'assisting health staff in immunization of families against Small Pox, T.B. etc.', as the most important responsibilities.

Though the responses of various respondents are very much scattered, yet broadly 'treatment of minor ailment', 'providing first aid in emergencies' and 'helping people in keeping their homes clean' appeared to be the three most important responsibilities. This indicated a tilt in favour of curative *vis-a-vis* preventive and promotive roles. However, this is not true in the case of CHW the 'pivot' of the scheme. According to the perception of CHW, the three most important responsibilities are 'treating minor ailments (47.8%)', 'promoting personal hygiene (35.8%)' and 'advising people about advantages of small family norm (35.5%)' shows a greater degree of balance in curative *vis-a-vis* promotive, preventive and educative roles.

The CHWs at the time of data collection had been in the field for over two months. Though it is a short period, yet an attempt was made to determine as to what exactly a CHW does, when he visits the village. The responses of community members on the one hand and most of the peripheral health functionaries, *i.e.* multipurpose/unipurpose health workers on the other hand, are presented in Table 8.

The responses of community members (recipient of services) indicate pre-occupation of CHW with the curative role; whereas the responses of multipurpose/unipurpose health workers indicate a mix of somewhat curative - promotive and preventive roles.

The opinion of the respondents was also sought as to which of the responsibilities amongst the many contained in

TABLE 6

PERCENTAGE DISTRIBUTION OF CHWs, VLWs, MPW/UPW, SUPERVISORS AND MEDICAL OFFICERS AT PHC LEVEL BY THREE MAIN RESPONSIBILITIES OF CHWs - RESPONSES TO OPEN-ENDED QUESTIONS

Responsibility	CHW N=299	VLW N=203	MPW/ UPW N=225	Other PHC Super- visors N=227	MO N=142
1. Treatment of minor ailments	I (47.8)	I (71.4)	I (57.8)	I (61.7)	II (59.2)
2. Assistance to health staff in preventing communicable diseases			II (53.8)		
3. First aid and emergencies				III (23.6)	
4. Assistance in immunization				II (54.6)	I (64.8)
5. Personal Hygiene	II (35.8)				
6. Advice on small family	III (35.5)				
7. Cleanliness of Homes		II (46.3)			
8. Informing people about availability of family welfare services		III (36.9)			III (31.7)
9. Referral of deliveries			III (37.8)		
10. Advice on immunization					
11. Depot holder for family welfare work					
12. Referral for sterilization/MTP					

I, II, III denote ranking based on frequency of responses.

TABLE 7

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS,
BDOs AND ZILA PARISHAD PRESIDENTS/MEMBERS BY
THREE MAIN RESPONSIBILITIES OF CHW - RESPONSES
TO OPEN-ENDED QUESTIONS

Responsibility	Community Leaders N=604	BDOs N=73	Zila Parishad N=42
1. Treatment of minor ailments	I (63.2)	II (47.9)	I (47.6)
2. Assistance to health staff in preventing of communicable diseases			
3. First aid and emergencies	III (34.8)	I (58.9)	II (42.9)
4. Assistance in immunization			III (33.3)
5. Personal Hygiene			
6. Advice on small family			
7. Cleanliness of Homes	II (31.7)	III (46.6)	
8. Informing people about availability of family welfare services			
9. Referral of deliveries			
10. Advise on immunization			
11. Depot holder for family welfare work			
12. Referral for sterilization/MTP			

I, II, III denote ranking based on frequency of responses

TABLE 8

PERCENTAGE DISTRIBUTION OF MULTIPURPOSE/UNIPURPOSE
WORKERS AND COMMUNITY MEMBERS BY WHICH CHW CARRIES
OUT WHEN HE VISITS THE VILLAGE

CHW Function	MPW/UPW N = 225	Community Members N = 5359
1. Treatment of minor ailments	50.7	83.3
2. First aid in emergencies	8.4	5.1
3. Health education	26.2	8.0
4. Maternal and Child Care	10.2	0.7
5. Communicable disease control	8.9	1.3
6. Malaria fever slide	19.1	8.0
7. Spray operations	31.1	8.7
8. Sanitation	32.0	4.1
9. Personal hygiene	4.0	3.0
10. Nutrition	4.9	1.5
11. Family welfare	22.2	7.2
12. Contraceptive depot holders	0.4	0.4
13. Registration of vital events	11.1	5.8
14. Referral service	16.4	4.5
15. Others	24.9	5.1

a multiple choice question, can be performed satisfactorily by the CHW. The responsibilities of CHW included in multiple choice questions (Appendix IIIb) are those which could be considered as possible responsibilities of CHW in the view of researchers. All categories of respondents were of the opinion that CHW would be able to perform all the responsibilities satisfactorily. The responses in respect of three responsibilities which he would be able to perform most satisfactorily are given in Tables 9 and 10.

TABLE 9

PERCENTAGE DISTRIBUTION OF VLWs, MPW/UPW OTHER SUPERVISORS AND MOs AT PHC LEVEL BY THREE MAIN RESPONSIBILITIES WHICH CAN BE SATISFACTORILY PERFORMED BY CHWs - RESPONSE TO

Responsibility	VLW N=203 Struc.	MPW/UPW N=225 Struc.	Other PHC staff N=227 Struc.	MO N=142 Struc.
1. Treatment of minor ailments	I (58.1)	II (88.9)		
2. Assistance to health staff in preventing of communicable diseases	II (18.2)	III (88.0)	III (82.4)	I (86.6)
3. First aid and emergencies				
4. Assistance in immunization			I (86.8)	I (86.6)
5. Personal hygiene				III (71.8)
6. Advice on small family	III (16.7)			
7. Cleanliness of homes	III (16.7)			
8. Informing people about availability of family welfare service				
9. Referral of deliveries				
10. Advice on immunization				
11. Depot holder for family welfare work		II (88.9)	II (83.3)	II (78.2)
12..Referral for sterilization/ MTP		I (91.8)		

I, II, III denote ranking based on frequency of responses.

TABLE 10

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS,
BDOs AND ZILA PARISHAD MEMBERS BY THREE MAIN
RESPONSIBILITIES WHICH CAN BE SATISFACTORILY
PERFORMED BY CHWs - RESPONSE TO

Responsibility	Community Leaders N=604 Struc.	BDOs N=73 Struc.	Zila Parishad N=42 Struc.
1. Treatment of minor ailments	II (90.1)		
2. Assistance to health staff in preventing of communicable diseases			
3. First aid and emergencies			
4. Assistance in immunization	I (91.7)	III (89.0)	III (90.5)
5. Personal Hygiene			
6. Advice on small family			
7. Cleanliness of homes			
8. Informing people about availability of family welfare service			
9. Referral of deliveries			
10. Advice on immunization	III (89.9)	II (90.4)	II (92.9)
11. Depot holder for family welfare work			
12. Referral for sterilization/ MTP		I (91.8)	I (95.2)

It can be seen that multipurpose/unipurpose health workers, BDOs and Zila Parishad members thought that the responsibility which can be performed most satisfactorily by the CHW is with reference to advising people about the availability of family welfare services. The community leaders, medical officers and supervisors at PHC, however, perceived 'assisting health staff in immunization as the responsibility' which can be performed most satisfactorily by the CHW. The views of village level workers for the same were with reference to 'treatment of minor ailments'.

CHAPTER IV

SELECTION PROCESS

In the context of evaluating several aspects of the CHW Scheme, the study of the selection process obtained in different States, as perceived by different people was considered important. This included extensive interviews with CHWs, community members, community leaders, village level workers, multipurpose/unipurpose workers, BDOs, Zila Parishad Presidents/members, Medical Officers of the PHC, Block Extension Educators, Sanitary Inspectors, Lady Health Visitors, and at the district level CMOs, Dy. CMOs (in-charge of CHW Scheme). In addition, interviews were also conducted with senior State level officials.

The PHC, district and State level interviews contained questions on selection procedure and criteria for selection. At the district level, a few questions were also asked to find out whether there were any modifications in the procedure followed for batch I and batch II of the CHWs. They were also asked to suggest reasons for deviation in procedure from the one suggested by the Government of India. The maximum number of questions on the selection process were, however, asked of the CHW. In addition to questions on awareness of the scheme and sources of knowledge about the scheme, he had to answer several other questions on agencies approached for nominations, involvement of the village community for selection of CHW, relationship of the CHW to the person proposing the name, number of names recommended, unanimity of selection, and whether selection was finalized in the village. This Chapter deals with the findings on dimensions common for all types of people interviewed and thereafter deal separately for each category of personnel interviewed. Attempts have been made to highlight wherever possible, inter-state differentials on the various aspects of the selection process.

Awareness before or after selection of CHW

Community members, community leaders, village level workers, BDOs and Zila Parishad Presidents/Members were asked questions on the above aspect (Table 11). Out of a total of 6,013 community members, nearly 1,510 (25%) came to know about the scheme before selection, while 3,450 (57.4%) came to know after the selection. A total of 17 (0.3%) respondents did not respond to this question. Of the 1,510 respondents, 831 (55.1%) from the MPW PHC area and 679 (44.9%) from non-MPW area came to know of the scheme before the selection. However, the fact that nearly half of the respondents came to know only after the selection indicates that sufficient publicity was not given to this scheme before it was implemented.

TABLE 11

PERCENTAGE DISTRIBUTION OF COMMUNITY MEMBERS
AS TO WHEN THEY CAME TO KNOW ABOUT THE SCHEME

Time of Awareness	MPW-PHC N = 3846	Non-MPW PHC N = 2167	Total N = 6013
Before selection	21.6	31.4	25.1
After selection	62.2	48.7	57.4
Not applicable	15.9	19.5	17.2
No response	0.3	0.4	0.3
Total	100.0	100.0	100.0

N = Number of community members.

The time of awareness was also ascertained from 604 community leaders, the results of which were presented in Table 12.

TABLE 12

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS
ACCORDING TO THE TYPE OF PHC AND THE TIME OF
AWARENESS OF THE CHW SCHEME

Type of PHC	Time of awareness			
	Before N = 463	After N = 126	N.A. N = 15	Total N = 604
MPW	63.1	69.0	46.7	63.9
Non-MPW	36.9	31.0	53.3	36.1
Total	100.0	100.0	100.0	100.0

N = Number of community leaders.

It is interesting to note that a total of 463 leaders out of 604 (76.6%) came to know about the scheme before the selection, while 20.9 per cent came to know after selection (Table 13). It will, thus, be noted that more of the leaders came to know before the selection as compared to community members, majority of which came to know only after the selection.

Considering the State level differentials, it may be noted that in Uttar Pradesh out of 143 community leaders interviewed, 116 (81.1%) came to know before the selection, whereas only 27 (18.9%) came to know after it. In Maharashtra, out of 80 leaders, 64 (80%) came to know before the selection and 15 (18.7%) after the selection. The proportion knowing before the selection is smaller for Andhra Pradesh and Gujarat where out of 80 leaders in each State, 53 (66.2%) and 57 (71.2%) respectively came to know before selection and 27 (33.8%) and 21 (26.2%) respectively after the selection. In Haryana and Bihar, out of 24 leaders in each State interviewed, 19 (79.2%) and 21 (87.5%) came to know before the selection. Thus, it can be observed that large majority of leaders in each of the States came to know about the scheme before the selection of CHW. Though, some inter-state variations are apparent, they may be largely attributable to variations in the sample sizes.

TABLE 13

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS/VLWs
ACCORDING TO THE TIME OF AWARENESS OF THE
CHW SCHEME - STATEWISE

States	Community Leaders		VLWs	
	% Before	N	% Before	N
Andhra Pradesh	66.2	80	58.1	31
Bihar	87.5	24	84.6	13
Gujarat	71.2	80	85.1	27
Haryana	79.2	24	100.0	4
Maharashtra	80.0	80	91.6	36
Madhya Pradesh	81.2	32	57.1	7
Rajasthan	66.7	24	36.3	11
Uttar Pradesh	81.1	143	85.0	40
Himachal Pradesh, Punjab and Chandigarh	74.1	31	75.0	8
West Bengal, Assam, Tripura, Mizoram, Meghalaya and Manipur	76.7	56	57.8	19
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	83.3	30	57.1	7
Total	76.6	604	74.8	203

N = Number of community leaders and village
level workers.

Among the 203 VLWs interviewed, 152 (74.8%) came to know about the scheme before the CHW was selected, while 39 (19.2%) of them came to know after the scheme was initiated. Thus, it may be observed that most of the village level workers were aware of the scheme even before it was started.

It will be worthwhile to mention here the State differentials. In Andhra Pradesh, for instance, out of 31 VLWs interviewed, nearly 18 (58.1%) knew the scheme before the CHW was selected. In Gujarat 23 (85.1%), in Maharashtra 33 (91.6%), and in Uttar Pradesh 34 (85.0%) knew the scheme before the CHW was selected. It appears, therefore, that the VLWs in most of the States were aware of the scheme before the CHW was selected.

Out of a total of 73 BDOs interviewed, 46 (63.0%) knew before the selection, and 22 (31.0%) came to know after the selection. Thus, by and large, majority of the BDOs were aware of the scheme before the selection.

Forty-two Zila Parishad Presidents/Members, were interviewed, of whom 26 (61.9%) knew before selection and 10 (23.8%) came to know after the selection.

In the case of community leaders, an attempt was made to know whether time of awareness of the CHW scheme was in any way associated with their position in the village.

Table 14 shows that 88.5 per cent Sarpanchs/Pradhans and 84.9 per cent Panchayat Members came to know of the scheme before selection, whereas only 67.3 per cent and 29.7 per cent of informal leaders came to know before and after the selection respectively. It appears that the informal leaders who are equally important source for legitimizing and popularising the programme in a rural set up were not involved as much as formal leaders.

Sources of knowledge about the scheme for the CHWs

Knowledge about the scheme was available to the CHWs from several sources, such as Panchayat Members, Panchayat Secretaries, BDOs, MO(PHC), Primary Health Centre Staff and others. Table 15 reveals that the major source of knowledge about the scheme was the Panchayat Member as mentioned by a total of 124 (41.5%) CHWs. Next in order is the PHC staff

TABLE 14

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS
ACCORDING TO THEIR POSITION IN THE VILLAGE
AND THE TIME OF AWARENESS OF THE
CHW SCHEME

Position in village	Time of awareness			Total N = 604
	Before N = 463	After N = 126	N.A. N = 15	
Sarpanch/Pradhan	88.5	8.1	3.4	100.0
Panchayat Member	84.9	14.3	0.8	100.0
Informal leader	67.3	29.7	3.0	100.0
Not specified	76.9	23.1	2.4	100.0
Total	76.7	20.9	3.4	100.0

N = Number of community leaders.

TABLE 15

PERCENTAGE DISTRIBUTION OF CHWs ACCORDING TO
THE SOURCE OF KNOWLEDGE ABOUT THE SCHEME

Source of knowledge	Multiple responses		
	One source N = 299	Two sources N = 299	Three sources N = 299
Panchayat Member	41.5		
Panchayat Secretary	9.7	2.7	
BDO	6.7	2.3	1.0
MO (PHC)	10.7	6.4	1.0
Other PHC staff	18.4	5.7	2.3
Others	12.7	5.3	1.3
No response	0.3		

N = Number of respondents.

with a total of 79 (18.4%). Panchayat Secretary and BDO were the less frequently mentioned sources. Thus, the most pre-dominant source, however, appears to be the Panchayat Member.

a. Community leaders: Of the 604 community leaders interviewed, 251 (41.5%) came to know about the scheme through the PHC staff. Next in order of importance was Panchayat followed by BDO, mentioned as a source by 75 (12.4%) leaders. The CHW himself was a source for 65 (10.8%) leaders. Interestingly enough, district and State officials were the least common sources and mass media was reported to be an insignificant one.

Reviewing the inter-state differentials it was observed that in eight States *viz.* Andhra Pradesh, Bihar, Gujarat, Haryana, Madhya Pradesh, Punjab, Rajasthan and Uttar Pradesh, the major informant of the CHW scheme were the PHC staff for nearly 50 per cent of the community leaders. Maharashtra and Uttar Pradesh are the two States in which the BDO had a significant role as an informant, next to the PHC staff. In Gujarat, Andhra Pradesh and Uttar Pradesh, the Panchayats were also a source. In the remaining States, the number of leaders interviewed is too small to yield any meaningful interpretation.

TABLE 16

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS
ACCORDING TO THE TYPE OF PHC AND THE STATUS
OF THE INFORMANTS ABOUT THE SCHEME

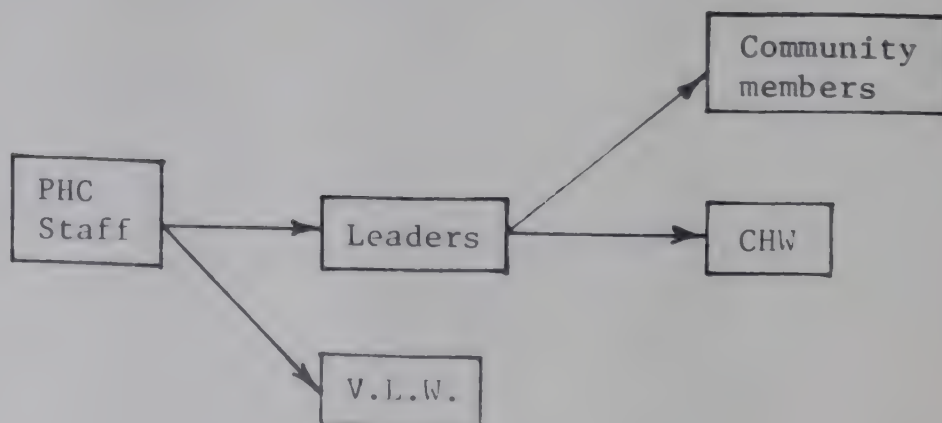
N	State offi- cials	Dist. offi- cials	PHC staff	BDO	Pan- chayat	CHW	Villa- ger	Mass Media	NA	NR	Total
386	0.8	3.6	40.2	14.2	16.3	9.1	8.3	5.7	0.5	1.3	100.0
218	2.8	2.8	44.0	9.2	12.8	13.8	6.9	4.1	2.3	1.3	100.0

N = Number of community leaders.

b. Community members: Regarding sources of knowledge about the scheme for community members, Panchayats appeared to be the most dominant source mentioned by 1,855 (30.8%) community members out of 6,013 community members interviewed. The next major source was CHW himself as mentioned by 1,180 (19.6%) community members. Surprisingly, mass media has been mentioned as a source by 1,039 (17.2%), BDOs by 928 (15.4%), District officials by 634 (10.4%). State officials were among the least mentioned 0.2 per cent. Since there is no direct contact between State officials and the community, hence this being mentioned a least source is understandable. It is, however, surprising that PHC staff have been mentioned by only 123 (2.0%) out of 6,013 respondents.

c. Village level workers: The trend as a major source of information for VLWs is similar to that of the community leaders, with the PHC staff being a major source (73) closely followed by the BDO (59). Unlike the community leaders, for at least 24 (11.8%) out of 203 VLWs, the source was mass media. The State and district level officials were a poor source of information.

Considering the inter-state differentials, BDO is the important source for VLWs in Maharashtra and Uttar Pradesh, while in Andhra Pradesh, Bihar and Gujarat, the PHC staff form the source. Possibly in the former two States, the BDO and VLW might have better contact and communication than in others. Uttar Pradesh stands out to be the only State with 11 (27.5%) out of 40 VLWs knowing about the scheme through mass media. The analysis presented with regard to the sources of information to different individuals as reported by them, leads to the emergence of a general pattern (Fig. 1). It is, however, to be noted that this pattern can be treated as common while variations from this model do exist. In some States, BDOs played a more active role than PHC staff.



Knowledge about name of selected CHW

a. Community members: Appendix III(b) shows that 4,999 (83.1%) out of 6,013 community members could tell the name of the CHW selected in their village. Only 185 (3.1%) were not aware of it. In most of the States, over 80 per cent members knew the names of CHWs. In Haryana, Rajasthan and West Bengal, 65 to 69 per cent reported to have this knowledge. It was only in Goa, Daman and Diu and Mizoram that this knowledge was among 50 to 52 per cent of the community members.

Of the 604 community leaders, 577 (95.5%) could tell the name of the selected CHW, while 15 (2.4%) could not tell. In the case of 12 (1.9%) leaders, the question was irrelevant as they did not know that a CHW was selected.

When the knowledge of name of CHW on the part of leaders was cross tabulated by type of PHC MPW/Non-MPW, no significant differentials were noted; 368 (95.3%) out of 386 leaders from MPW PHC and 209 (95.8%) out of 218 from non-MPW PHC area could tell the name of the selected CHW.

When the knowledge about the name of selected CHW was matched against the position of the leaders in the village, it was found that 141 out of 149 (94.6%) Sarpanchs/Pradhans, 130 (97.7%) out of 133 Panchayat Members and 293 (94.8%) out of 309 informal leaders could tell the name of the CHW. This finding is somewhat different from another study¹ conducted recently according to which informal leaders had very little knowledge about the persons selected and did not actively participate in the final selection.

Agencies approached by CHW for his nomination

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A relevant aspect of the dynamics of selection of CHWs is whether they approached someone for getting their names nominated and if so, to whom did they approach. Table 17 indicates that 234 out of 299 (78.2%) approached Sarpanch/Village Pradhan for their nomination. Of these, 92 (30.7%)

1. Vohra, H.R., Ramaiah, T.J., Rao, K.G., Singhal, D.S. and Sharad Kumar: Dynamics of Selection of Community Health Workers, National Institute of Health and Family Welfare, New Delhi. June 1978 (Mimeographed).

approached more than one sources. Of 168 (56.1%) who approached Panchayat Members, 19 (11.3%) used another additional source and four (2.3%) two such sources. Very few CHWs 22 (7.3%) approached Panchayat Secretary or MO/PHC (5.6%). It is worth noting that in the present study around 34 per cent approached either the Sarpanch, Pradhan or Panchayat Secretary, while in another recently concluded study¹ confined to four States, nearly 89 per cent of CHWs approached these two sources. This may also include CHWs proposing their own names although this is not evident from the table.

TABLE 17

PERCENTAGE DISTRIBUTION OF CHWs ACCORDING TO THE APPROACH THEY HAD FOR THEIR NOMINATIONS

When they approached	Multiple Responses		
	One source N = 299	Two sources N = 299	Three sources N = 299
Sarpanch/Pradhan	47.5	30.7	
Panchayat Member	48.5	6.4	1.3
Panchayat Secretary	3.7	3.0	0.7
BDO	0.3	0.7	-
MO (PHC)	-	4.7	1.0
Others	-	2.2	1.0

Involvement of the village community in the meeting for selection of CHWs

Of the 299 CHWs responding to the question about the involvement of village community in the meeting for selection 226 (75.6%) stated that the village community was involved, while only 69 (23.7%) stated that they were not involved. It possible that involvement might have been differently interpreted by the respondents as the large number of interviewers employed in this study to cover 24 States might have

put the question in slightly different way. By and large, the village communities appears to have been involved in the process. There was no significant differential in this regard between MPW and non-MPW PHCs.

Relation of CHW to the person proposing his name

Of 299 CHWs, 253 (84.6%) had no relationship with persons proposing their names, which appears to reflect minimal personal bias in proposing the names. Only 12 (4.0%) names were suggested by their uncles, four (1.3%) by brothers, three (1.0%) by cousins, and two (0.7%) by their fathers. Kinship groups were, therefore, not a predominant source of influence in suggesting names.

Number of persons recommended for CHW

In a selection of this nature, the scope for selection is a crucial dimension. How many names were recommended for selection as CHW? As many as 139 (46.5%) out of 299 CHWs responded that only one name was suggested, 53 (17.7%) stated that two names were suggested, and 38 (12.7%) mentioned that three names were put up (Table 18). Single names being

TABLE 18
PERCENTAGE DISTRIBUTION OF CHWs ACCORDING
TO THE TYPE OF PHC AND THE NUMBER OF
NAMES RECOMMENDED FOR CHW

Type of PHC	N	Number of names recommended						Un- known	Total
		1	2	3	4	5			
MPW	183	45.4	16.9	11.5	9.8	10.4	6.0	100.0	
Non-MPW	112	48.2	19.6	15.2	8.0	5.4	3.6	100.0	
Unknown	4	50.0	-	-	-	-	50.0	100.0	
Total	299	46.5	17.7	12.7	9.0	8.4	5.7	100.0	

N = Number of CHWs.

suggested was the common pattern, and the trend was the same for MPW and non-MPW PHCs. The findings of another study¹, exclusively devoted to the dynamics of selection process in four States analysed this aspect in two stages - (i) at the stage of preliminary selection; and (ii) recommendations for final selection. The screening process was clearly reflected in the fact that while in only 31 per cent cases one name was suggested in the initial stage, this percentage rose to 50 in the final selection thereby reflecting a process of crystallisation of opinion.

A related question was put to CHWs to find out whether the selection was unanimous. Out of 299 CHWs, 231 (77.2%) expressed that the selection was unanimous, while only 67 (22.4%) felt that it was not so. There was no significant difference between MPW and Non-MPW PHCs in this regard.

a. Position of community leaders and number of candidates nominated: Of 604 community leaders, 149 (24.7%) were Sarpanch Pradhans (Table 19). Of these, 54 (36.3%) suggested only one

TABLE 19

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS ACCORDING TO THEIR POSITION IN THE VILLAGE AND THE NUMBER OF CANDIDATES NOMINATED FOR THE SELECTION OF CHW

	Number of candidates nominated							
	N	01	02	03	04 & 05	06+	Un- known	Total
Sarpanch/ Pradhan	149	36.3	15.4	15.4	13.4	6.1	13.4	100.0
Panchayat Member	133	32.3	10.5	15.1	11.3	9.0	21.8	100.0
Informal leader	309	29.5	12.6	9.7	7.1	6.8	34.3	100.0
Not specified	13	38.4	7.7	30.8	7.7	7.7	7.7	100.0
Total	604	31.9	12.8	12.8	9.6	7.1	25.8	100.0

N = Number of community leaders.

name, and 23 each (15.4%) suggested two and three names. Among 133 Panchayat Members, 43 (32.3%) suggested one name, 10.5 per cent suggested two names and another 15 per cent suggested three names. It is worth observing that only 29.5 per cent of informal leaders suggested only one name each, and their percentage in suggesting more than one name is also much less than other categories of leaders. They also represent 34.3 per cent of "unknown" category of responses, as compared to the overall percentage of 25.8. It appears that informal leaders have been less active in the entire process.

b. Inter-state differentials in community leaders' knowledge about number of persons nominated: The overall trend shows that States were very similar in nominating only one person as reported by community leaders. Except for Maharashtra and Gujarat where there was some distribution from one to five nominations and also in Uttar Pradesh to some extent, in the rest of the States have one person nomination only. The details of the same can be seen in Appendix IV(d).

*Involvement of different persons/agencies
in the selection process*

An attempt was made to find out if, the community leaders' position was in any way related to the involvement of Gram Sabha in the selection process.

Of the three category of positions (Table 20), most of the Panchayat Members (54.9%) felt that the Gram Sabha was involved as against 49 per cent of Sarpanch/Pradhan and 37.9 per cent of informal leaders. Thirty-two to 38 per cent of the respondents in all the three positions felt that the Gram Sabha was not involved. Obviously, the response to this question is heavily loaded with perception and interpretation components which render the findings subjective to some extent. However, the results do indicate the need for a more meaningful involvement of the Gram Sabha in the selection process.

On the same dimension, State level differentials were also worked out (Appendix IV(c)). The knowledge of community leaders about the involvement of Gram Sabhas in the selection varied from State to State. As many as 52 out of 80 (65%) in Andhra Pradesh, 89.5 per cent in Punjab, 50 per cent in

TABLE 20

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS ACCORDING
TO THEIR POSITION IN THE VILLAGE AND INVOLVEMENT
OF GRAM SABHA IN THE SELECTION OF CHW

Position in village	N	Whether Gram Sabha was involved				Total
		Yes	No	Do not know	No response	
Sarpanch/Pradhan	149	49.0	38.9	12.1	-	100.0
Panchayat Member	133	54.9	32.3	11.3	1.5	100.0
Informal Leader	309	37.9	32.4	29.1	0.6	100.0
Not specified	13	46.2	46.2	7.6	-	100.0

N = Number of community leaders.

Maharashtra, 37.8 per cent in Gujarat, 48.3 per cent in Uttar Pradesh had such knowledge. In Rajasthan as many as 58.5 per cent had no knowledge of the Gram Sabha's involvement, while 35.7 per cent in Uttar Pradesh, 29.7 per cent in Maharashtra and 22.5 per cent in Gujarat gave a similar response.

For ascertaining BDO's involvement in the selection of CHWs, their role in the selection process was analysed. Of a total of 227 BDOs, 42 (18.9%) indicated involvement in informing the community about the scheme, and about 39 (17.5%) indicates taking part in explaining the scheme to the villagers. They were less involved (12.6%) in the preparation of list of names and in conducting the panchayat meeting only 29 out of 222 (13.1%) were involved. In the finalization of names and in conducting interviews only 10.8 per cent of them were involved.

State level analysis does reflect some significant differentials. In Uttar Pradesh, 74 (57.7%) BDOs were involved in some aspect of the selection process as compared to 52 (41.3%) who were not at all involved. The proportion of

involvement and non-involvement was almost equal in Maharashtra with 34 (48.6%) and 36 (51.4%) respectively. In Gujarat and Andhra Pradesh a larger number of BDOs were not involved. The proportion involved and not involved was 17 (24.2%): 53 (75.8%) in Gujarat and 11 (15.7%): 59 (84.3%) in Andhra Pradesh. This disproportion was apparent in Rajasthan also with 2 (9.5%) involved and 19 (90.5%) not involved. Haryana was a singular exception with all the 21 (cent per cent) BDOs involved in one or the other aspect. The details of the same can be seen from Appendix IV(f).

Regarding responses of Zila Parishad Presidents/Members, out of 294 responses regarding involvement, 230 (78.2%) were positive. The disproportionate non-involvement in terms of responses however, was more apparent in Uttar Pradesh 7 (9.0%) involved vs. 70 (91.0%) non-involved, Punjab 3 (21.4%): 11 (78.6%), Madhya Pradesh 1 (3.6%): 27 (96.4%), Maharashtra 15 (30.6%): 34 (69.4%), Gujarat 12 (28.5%): 30 (71.5%). The only happy exception is Assam where all the seven (cent per cent) responses indicated involvement in the CHW selection. The details of the same are available in Appendix IV(g).

Difficulties faced in the selection of CHWs

Of a total of 604 community leaders, 484 (80.1%) reported that they did not experience any difficulty (Table 21). The proportion expressing this view was almost the same for Sarpanch/Pradhar. (89.3%) and Panchayat Members (81.2%). While amongst influential persons, 232 out of 309 (75.1%) reported that they faced no difficulties whereas 71 (23.0%) did not respond. Only two Panchayat Members and two local leaders reported that they have experienced pressure from influential persons which was a source of difficulty. Pressure from political leaders was reported to be minimum, as is evident from Table 21 that only one Panchayat Member expressed it.

When State-wise differentials were studied; it was found that all community leaders of Meghalaya (cent per cent) reported no difficulty, followed by Bihar (91.7%). In Pondicherry 50 per cent leaders reported no difficulty in selection. The columns on specific difficulties were virtually empty with a cluster of responses in "no response" category for most of the States. Probably, there was some inhibition or hesitation in expressing such difficulties. Two leaders from Orissa and two from Uttar Pradesh expressed

TABLE 21

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS ACCORDING TO DIFFICULTIES EXPERIENCED
IN THE SELECTION OF CHW, BY THE POSITION OF COMMUNITY LEADERS IN THE VILLAGE

Difficulties	N	No diffi- culties	Difficulties in selection of CHW									Total
			Pres- sure from Sar- panch/ Pradhan	Pres- sure from influ- ential persons	Pres- sure from poli- tical leaders	Proper candi- date not avail- able	Too many candi- dates/ difficul- ty to decide	Diffi- culties not speci- fied	Less time, scheme was launched in hurry	No res- ponse/ un- known		
Sarpanch/ Pradhan	149	89.3	-	-	-	-	0.7	-	0.6	9.4	100.0	
Panchayat Members	133	81.2	-	1.5	0.8	-	-	1.5	-	15.0	100.0	
Influential persons	309	75.1	0.3	0.7	-	0.3	0.6	-	-	23.0	100.0	
Not specified	13	84.6	-	-	-	-	-	-	-	15.4	100.0	
Total	604	80.1	0.2	0.7	0.2	0.2	0.5	0.3	0.1	17.7	100.0	

N = Number of community leaders.

pressure from influential persons as a source of difficulty. Further details of the same can be observed from Appendix IV(h).

Of a total of 73 BDOs, 25 (35.2%) expressed no difficulty in the selection of the CHW, while 8 (10.9%) expressed political and party pressure (3 from Gujarat, 2 from Uttar Pradesh, one each from Maharashtra and Madhya Pradesh). It is interesting to note that while 8 (10.4%) out of 73 BDOs did experience political pressure, the proportion of community leaders expressing the same difficulty was much less. Five (6.8%) BDOs reported wrong selection, nine (12.3%) reported pressure from local leaders due to differences of opinion about the candidate to be nominated and three (4.1%) were not involved in the selection, while 7 (9.6%) reported that sufficient number of qualified candidates were not available (three such responses were from BDOs of Maharashtra). Seven BDOs felt that it was too early to evaluate.

The perception of the PHC staff regarding the difficulties experienced by them in selection was also ascertained on a four point scale (Table 22). Many Block Extension Educators (20.3%) expressed 'lot of difficulties' in this process as

TABLE 22

PERCENTAGE DISTRIBUTION OF PHC STAFF
ACCORDING TO DIFFICULTIES FACED BY
THE COMMUNITY IN SELECTION OF CHW

PHC staff	N	Difficulties faced by community					Total
		Can not say	Lot of diffi- culties	Some diffi- culties	No diffi- culty	Un- known	
MO Incharge	95	16.0	12.8	33.0	38.2	1.4	100.0
MO	47	15.0	15.0	36.0	34.0		100.0
BEE	75	21.6	20.3	35.1	23.0		100.0
SI/HI	148	14.6	11.1	27.1	45.8	1.4	100.0
Unknown	4		33.4	33.3	33.3		100.0
Total	369	16.3	14.1	31.5	37.6	0.5	100.0

N = Number of PHC staff.

compared to MO-in-charge (12.8%), MO (15%) and Sanitary Inspector/Health Inspector (11.1%). 'Some difficulties' were noted by 33 to 36 per cent of MOs and BEEs. Many Sanitary Inspectors/Health Inspectors expressed 'no difficulty' (45.8%) as compared to BEE's (23%), MO (34%) and MO-in-charge (38.2%)

Satisfaction with selected CHWs

Satisfaction with selection process was studied in relation to the position of the village leaders.

As Table 23 indicates, 86.6 per cent of all leaders were satisfied with the selection of CHWs, while only 6 per cent expressed dissatisfaction. There was no significant difference in this regard between the three types of leaders classified in terms of their position where the satisfaction rate varied from 83.8 per cent amongst informal leaders to 89.5 per cent amongst Panchayat Members.

TABLE 23

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS
ACCORDING TO THEIR POSITION IN THE VILLAGE
AND WHETHER THEY WERE SATISFIED WITH THE
WAY IN WHICH CHW WAS SELECTED

Position in the village	N	Whether satisfied with the way CHW was sel					To
		Yes	No	Cannot say	No response		
Pradhan/ Sarpanch	149	88.6	6.7	2.7	2.0		10
Panchayat Member	133	89.5	3.0	3.0	4.5		10
Informal Leader	309	83.8	7.1	4.8	4.3		10
Not specified	13	100.0					10
Total	604	86.6	6.0	3.8	3.6		10

N = Number of community leaders.

A more pointed question was addressed to the village leaders whether they were satisfied with the CHWs in their respective villages. About 94 per cent of the leaders were satisfied and only 4.1 per cent were dissatisfied. This percentage was again the same for the leaders in three different positions. Evidently a large majority of leaders were satisfied with the selected CHWs, in general and the respective CHWs in particular (Table 24).

TABLE 24

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS
ACCORDING TO THEIR POSITION IN THE VILLAGE
AND WHETHER THEY WERE SATISFIED WITH THE
CHW OF THEIR VILLAGES

Position in the village	N	Whether satisfied with CHW of their village				Total
		Yes	No	Cannot say	No response	
Sarpanch/ Pradhan	149	93.3	3.4	1.3	2.0	100.0
Panchayat Member	133	96.2	1.5	0.8	1.5	100.0
Informal Leader	309	93.2	5.8	0.3	2.7	100.0
Not specified	13	100.0	-	-	-	100.0
Total	604	94.0	4.1	0.7	1.2	100.0

N = Number of community leaders.

Attitude towards CHW

In order to assess the attitude of leaders towards the CHWs, a series of seven statements reflecting certain positive and negative aspects were posed to them. They were asked to state whether they agreed or disagreed with each of the statements. The response pattern is quite interesting and significant in that they clearly discriminated between different statements. These are presented in Table 25.

TABLE 25

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS
 ACCORDING TO THEIR AGREEMENT/DISAGREEMENT
 WITH DIFFERENT STATEMENTS EXPRESSING
 OPINION ABOUT THE CHW

Statement	Agree	Dis- agree	Un- certain	No Resp.	Total N = 604
CHW is more acceptable to community than outsider	89.7	7.5	0.7	2.1	100.0
CHW has better under- standing of community and its health problems than an outsider	96.2	1.0	1.0	1.8	100.0
CHW is not respected enough because people are too familiar with him	25.3	68.4	4.0	2.3	100.0
CHW is more sincere and conscientious than an outsider as he belongs to community	93.6	2.0	2.3	2.1	100.0
The control by community means too many masters	36.3	52.0	9.4	2.3	100.0
In the village there is limited choice for selecting a suitable CHW	45.9	46.8	5.3	2.0	100.0
CHW is more answerable to the community than an outsider	92.8	2.0	2.9	2.3	100.0

Figures are in percentages.

Of the different items of opinion regarding the CHW listed, 581 out of 604 (96.2%) community leaders agreed that the CHW will have a better understanding of the community and its health problems as compared to an outsider. Next most agreed upon item was that CHW is more sincere and conscientious than an outsider as he belongs to the community, as expressed by 93.6 per cent of community leaders. A related opinion *viz*: 'CHW being more acceptable to community than an outsider' was agreed to by 89.7 per cent of community leaders. As against this, 46.8 per cent, 52 per cent and 68.4 per cent leaders disagreed with the statements 'in the village there is limited choice for selecting a suitable CHW', 'the control by community means too many masters' and 'CHW is not respected because people are too familiar with him', respectively. These responses indicate that among community leaders, in general, there is a positive attitude towards the CHW. Being a scheme based heavily upon community participation and involvement, the overall positive attitude towards the CHW argues well for the success of the scheme.

Awareness of selection criteria

An important aspect of the selection process is the publicity given to various selection criteria and their awareness in the community. Awareness of the same is a pre-requisite for selection of the right type of a person as CHW. The responses of the community leaders as presented in Table 26 indicate that majority (86.9%) were told about the fact that the CHW could be a practitioner of traditional system of medicine/Homoeopathy. About 78 per cent of the leaders informed that the CHW should be able to serve for at least three years. The next criteria emphasized by 75.3 per cent of leaders was that the CHW should not belong to any group or political organisation in the village. Close to this were: (i) CHW could have any vocation (74.7%) and (ii) CHW could be of either sex (73.3%). The least emphasized criterion was social-service mindedness of the CHWs (28.6%).

The views of PHC staff were also ascertained regarding the three most important selection criteria. The responses are presented in Table 27.

The most important criteria as 'CHW should be permanent resident of the village' has been reported by

TABLE 26

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS WHO
TOLD/DID NOT TELL ABOUT DIFFERENT STATEMENTS
REGARDING SELECTION CRITERIA

Statement	Told	Did not tell	No response	Total N = 604
CHW should be permanent resident of the village	34.1	65.6	0.3	100.0
The CHW can be of any vocation	74.7	24.9	0.4	100.0
The CHW should at least be able to read and write having minimum formal education upto sixth standard	30.3	69.5	0.2	100.0
CHW should be able to spare at least 2-3 hrs. a day for community health activities	61.6	38.2	0.2	100.0
The CHW should be physically active	48.7	50.7	0.6	100.0
The CHW should be able to serve for a minimum period of three years	78.1	20.9	1.0	100.0
The CHW should be acceptable to all sections of the community	40.4	59.6	-	100.0
The CHW should be social-service minded	28.6	71.4	-	100.0
The CHW should not belong to any group or political organisation of the village	75.3	24.7	-	100.0
The CHW may also be a practitioner of traditional medicine or homoeopathy	86.9	12.7	0.4	100.0
The CHW can be of either sex	73.3	26.7	-	100.0

TABLE 27

PERCENTAGE DISTRIBUTION OF PHC STAFF ACCORDING
TO THEIR VIEWS REGARDING THE IMPORTANT
SELECTION CRITERIA

	1st important criteria N = 369	2nd important criteria N = 369	3rd important criteria N = 369
CHW should be permanent resident of village	89.4		0.6
CHW can be of any vocation	1.1	4.6	1.9
CHW should be able to read and write and educated upto sixth standard	5.7	59.2	1.9
CHW should be able to spare 2-3 hrs. daily	2.2	19.8	19.6
CHW should be physically active	0.6	9.2	8.7
CHW should be able to serve for a minimum of three years		5.7	8.4
CHW should be acceptable to all sections of the community	0.3	0.6	58.4
No response	0.7	0.7	2.4
Total	100.0	100.0	100.0

N = Number of PHC staff.

89.4 per cent of the PHC staff. The second most important criteria mentioned by sizeable number of PHC staff was that the CHW should be of sixth standard with ability to read and write (59.2%). It will be noted that these were the least important criteria as was understood by the community leaders. It could be due to varying emphasis in publicity or differences in perception itself. The third most important criteria mentioned by 58.4 per cent of PHC staff is his acceptability to all sections of the community.

The opinion of district officials regarding selection criteria was also ascertained. Educational attainment was the most important selection criteria emphasized by 80 (56.3%) officials, followed by permanent residence by 63 (44.4%), social service mindedness by 51 (35.9%), not belonging to any political organisation by 48 (33.8%) and could be either sex by 47 (33.1%). Selection criteria such as 'being physically active', 'belonging to scheduled caste and tribe' and 'practising traditional system of medicines' were emphasized by only 33(23.2%) of the district officials.

Selection procedures adopted in different States

Knowledge of district officials was ascertained with regard to the selection procedure adopted in the States. Majority of them 52 (36.6%) were not aware of the procedure. Panchayats and informal leaders suggesting the names and staff of PHC finalising the selection was another common procedure mentioned by 51 (35.9%) of them. In case of more than one nomination, selection based on interview at PHC was another procedure mentioned by 43 (30.3%). Names being sent by village Panchayat and Gram Sabha and final selection being made by BDO and MO (PHC) was another suggested procedure by 23 (16.2%), of the district officials interviewed.

It is quite evident that a large proportion of officials at district level did not know the actual procedure adopted for selection of CHWs. Uttar Pradesh, Andhra Pradesh and Maharashtra had a majority of such responses. This warrants the necessity of proper orientation to the district staff on selection procedures.

The most commonly known procedure as mentioned by State Officers was the interview by MO and BDO of the candidates recommended by Panchayat, with due publicity in the village by BDO and PHC staff.

State officials were further asked regarding the emphasis on selection criteria in their States. About nine criteria were almost equally emphasised by them. These included: either sex, permanent resident of the village, possessing sixth standard education, social minded, ability to devote 2-3 hours per day, ability to serve for three years, acceptable to all sections, not belonging to any political group, and could be a practitioner of indigenous system of medicine.

Deviation in selection criteria for batch I and II of CHWs in the different States

In majority of cases, there was no change in criteria for selection from first to second batch of CHWs, except in Haryana where in the second batch younger people were discouraged and age limit was raised upto 50 years and ex-service men were preferred.

Reasons for making the changes were (i) female candidates were preferred as they were invariably available to the community, (ii) political pressures, (iii) ex-service men being better and more disciplined, and (iv) no candidate with the requisite educational qualifications were available as in the case of Sikkim.

CHAPTER V

PROFILE OF COMMUNITY HEALTH WORKERS

By the time the data collection started, two batches of Community Health Workers were already selected. The first batch had completed its training and the second batch was under training. The data on socio-economic characteristics such as age, sex, marital status, education, occupation etc. of both the batches of CHWs were collected. The results obtained are presented in this Chapter. An attempt was made to study the inter-State variations that existed in the distributions of these characteristics and also the extent of their deviations, if any, from the guidelines suggested by the Government of India with regard to them.

Age

The average age of CHW is found to be 26 years; it being lowest in Rajasthan (24.2 years) and highest (29.2 years) in Maharashtra. Among the selected CHWs, 13.4 per cent were below the age of 19 years and only 2.8 per cent were of the age 40 years or above. More than one-fifth of the CHWs were in their teenages in the States of Rajasthan and Uttar Pradesh. The details are presented in Appendix V(a).

Sex

It is observed that the Community Health Workers are drawn largely from amongst males who constituted 93.7 per cent. The remaining 6.3 per cent are females. Further, female representation is nil in Rajasthan and is very less in Uttar Pradesh (0.7%), Madhya Pradesh (0.7%) and Haryana (0.9%) in comparison to Eastern States together, namely, West Bengal, Assam, Tripura, Mizoram etc., where 25.9 per cent of CHWs are females (Appendix V(b)).

Marital status

Amongst the CHWs, it has been found that 23.2 per cent are 'never married' and 73.8 per cent are married persons. A small percentage (0.7%) are widows or separated. Although the composition of widows/separated remained small in all States, yet the magnitude of 'never married' varied substantially from State to State. While only 8.5 per cent of CHWs from Uttar Pradesh are 'never married', yet as large as 46.9 per cent of CHWs from Eastern States are 'never married', followed by Andhra Pradesh (36.6%) and Haryana (32.4%). Details are shown in Appendix V(b).

Educational status

It may be observed from Appendix V(c) that about 0.3 per cent of the CHWs are illiterates, who belong to Andhra Pradesh, Himachal Pradesh, Punjab and Chandigarh. Among others, 29.1 per cent had primary education, 62.1 per cent had 'High School' education, 8.5 per cent had college or higher education. Inter-State differentials are quite significant. As large as 86.9 per cent of CHWs from Rajasthan had only primary education, followed by Gujarat (34.2%). About 26 per cent of CHWs from Bihar are reported to have had college or higher education, followed by Uttar Pradesh (17.4%), and Himachal Pradesh, Punjab and Chandigarh together (17.2%), Maharashtra (0.6%) and Rajasthan (0.9%).

The guidelines issued by the Government of India state that the person selected should have had formal education upto sixth standard, but 29.4 per cent of the selected CHWs do not fulfil this criteria. This deviation appears to be maximum in Rajasthan (86.9%) followed by Gujarat (34.2%) and it is minimum in Madhya Pradesh (14.3%).

Occupational pattern

The type of occupation engaged in by CHW has a significant bearing on his/her performance of the activities and on the degree of success as a CHW. Over 70 per cent of CHWs were reported (Appendix V(d)) to be engaged in agriculture which also constitutes the single largest group in each of the State too. However, it varies from 51.9 per cent in Haryana to 85.0 per cent in Uttar Pradesh.

It is significant to note that about 1.8 per cent of CHWs are drawn from amongst local *dais* and private practitioners who otherwise are also engaged in health activities. Though small in composition, their representation exists in all States. It is expected that the addition of CHWs, responsibilities would strengthen their present health activities.

The CHWs who were unemployed are only 4.7 per cent. The composition of this group is found to be largest (22.8%) in Eastern States followed by Haryana (15.7%). However, Bihar, Maharashtra and Rajasthan did not report any such cases.

On further examination, it was found that most of the unemployed were educated (college or above) and hence, are likely to leave this work as soon as they are able to find better work.

Although, 4.6 per cent of all CHWs are shopkeepers, its magnitude is found to be as large as 10.3 per cent in Gujarat, 13.0 per cent in Haryana and 8.7 per cent in Rajasthan. How medicines and drugs supplied to them would be made use of by these CHWs has to be seen. Further evidence with regard to their attitude towards and perception of health activities in general and roles and responsibilities of CHW in particular can be seen elsewhere in this report which may provide certain indirect evidence about their likely functioning as CHWs.

Caste

The guidelines suggested by the Government of India specify that suitable representation should be given to Scheduled Caste and Scheduled Tribe candidates in the selection of CHWs and wherever necessary, the qualifications may be relaxed to facilitate the same. It is found (Appendix V(e)) on analysis that 21.2 per cent of the CHWs belong to Scheduled Castes and Tribes. Their representation was found to be the highest in Eastern States (51.9%) followed by Andhra Pradesh (34.6%) and Haryana (23%). Their representation was found to be the smallest in Maharashtra (9.1%).

Place of residence

About 98 per cent of the CHWs were reported to be the residents of the villages from where they were selected. However, it should be noted that about 0.6 per cent (though

small) did not belong to the same village and another 1.5 per cent did not specify it. In other words, it might be surmised that the percentage of CHWs not belonging to the same village was 2.1. It should further be noted that such candidates were reported from only few States, namely, Haryana (4.6%), Eastern States (1.9%), Maharashtra (1.2%), Andhra Pradesh (0.6%) and Gujarat (0.2%). The whole of 'unspecified' group was reported from Gujarat only. Thus, while the guidelines clearly state that the selected CHWs should be residents of the same village, there exists slight departure from the same.

CHAPTER VI

TRAINING

Training of personnel to impart knowledge, develop skill and inculcate proper attitudes is the most important amongst various inputs provided in the scheme. This is particularly true in the case of Community Health Workers Scheme as would be evident from the efforts made at the planning stage to ensure appropriate quality and quantity of training of CHWs. In the present study, therefore, an attempt was made to evaluate the training component of the CHW programme on a number of dimensions such as pre-requisites for training, the training process in terms of duration, content and methods used, the achievements of trainees, need for refresher courses, and the difficulties involved in training. On account of various difficulties involved in assessing the development of skills and inculcation of proper attitudes, the evaluative effort has been restricted to the area of knowledge only.

For the purpose of assessing knowledge, questions including multiple choice questions on various areas of training were administered to CHWs. The assessment covered their competencies in:

- a. tackling certain symptoms and physiological conditions;
- b. providing referral services for patients;
- c. managing emergencies;
- d. preventing deaths in infants and deaths from water-borne diseases; and
- e. tackling certain diseases.

These items were scored. However, no negative scoring or weighted scoring was done. Thus, only positive responses have been taken into consideration. A sample of these questions is given at Appendix VI(a).

Pre-requisites for training

Venue of training, physical facilities, availability of properly trained trainers, manuals, kits and audio-visual aids were some of the dimensions of pre-requisites for training. The information with regard to status of training of trainers and the place where they were trained is presented in Table 28.

It can be seen that 38.5 per cent of trainers were not at all trained to undertake training of CHWs, the percentage for MO-incharge, other MO, BEE, SI/HI/LHV being 27.1, 55.3, 44.0 and 37.2 per cent respectively. Of those who were trained, 59.1 per cent were trained at HFPTCs, the range

TABLE 28

PERCENTAGE DISTRIBUTION OF TRAINERS OF CHWs
ACCORDING TO THEIR TRAINING STATUS
AND VENUE OF TRAINING

Categories of Trainers	Trained							Not trained
	CTI	HFPTC	State H.Q.	Dist. H.Q.	PHC	Others	Total	
MO Incharge (N=95)	4.3	62.9	5.7	21.4	0.0	5.7	72.9	27.1
MO (N=47)	0.0	90.5	0.0	9.5	0.0	0.0	44.7	55.3
BEE (N=75)	0.0	47.6	2.4	23.8	11.9	14.3	56.0	44.0
SI/HI/LHV (N=148)	3.2	53.8	2.1	14.0	9.7	17.2	62.8	37.2
Unknown (N=4)	0.0	100.0	0.0	0.0	0.0	0.0	33.3	66.7
Total (N=369)	2.6	59.1	3.1	17.6	7.0	10.6	61.5	38.5

Appendix IV

DISTRIBUTION OF DIFFERENT CATEGORIES OF PHC STAFF BY
THEIR DURATION OF SERVICE IN PRIMARY HEALTH CENTRE

Experience in PHC (in years)	Medical Officer		Block Extension Educator		Lady Health Visitor	
	Number	Percentage	Number	Percentage	Number	Percentage
≤ 2	54	31.0	6	7.5	17	14.2
2 - 4	32	18.4	6	7.5	12	10.0
4 - 6	36	20.7	7	8.8	17	14.1
6 - 8	22	12.7	17	21.2	20	16.7
8 - 10	20	11.6	12	15.0	13	10.8
10 - 12	3	1.7	14	17.5	13	10.8
12 - 14	2	1.1	13	16.3	10	8.4
14 - 16	2	1.1	3	3.7	9	7.5
16 +	2	1.1	2	2.5	9	7.5
N. A.	1	0.6	-	-	-	-
Total	174	100.0	80	100.0	120	100.0

The responses regarding the use of audio-visual aids, by the trainers as given in Table 30, indicate that they were never utilized by 26.3 per cent and occasionally utilized for training by 46.9 per cent. One of the reasons for non-utilization of audio-visual aids could be their non-availability. There was a good deal of uniformity in responses of various categories of trainers.

TABLE 30

PERCENTAGE DISTRIBUTION OF TRAINERS ACCORDING TO UTILIZATION OF AUDIO-VISUAL AIDS

Categories of Trainers	Utilization of audio-visual aids				
	Never	Fre- quently	Occasion- ally	Can't say	Unknown no response
MO Incharge (N=95)	37.5	20.8	38.6	0.0	3.1
Other Medical Officers (N=47)	29.8	21.3	40.4	4.3	4.2
BEE (N=75)	17.3	26.7	52.0	1.3	2.7
SI/HI/LHV (N=148)	23.0	20.9	52.0	3.4	0.7
Unknown (N=4)	0.0	0.0	33.3	66.7	0.0
Total (N=369)	26.3	21.9	46.9	2.7	2.2

Similar picture obtains, more or less with regard to availability and utilization of manuals as is shown in Tables 31 and 32. Again, the reasons for their non or low-utilization as indicated in Table 32, could be their non-availability. This assumption is supported by the responses

TABLE 31

PERCENTAGE DISTRIBUTION OF CHWs OF BOTH BATCHES WITH REGARD TO AVAILABILITY OF MANUALS WITH REFERENCE TO TRAINING - STATEWISE

States/Union Territories	Total number		Before training (per cent)		During training (per cent)		After training (per cent)		Not at all (per cent)	
	I	II	I	II	I	II	I	II	I	II
Andhra Pradesh	195	201			79.4	19.9	10.3	21.4	10.3	58.7
Bihar	98	91			58.2	26.4	41.8	51.6	-	22.0
Gujarat	190	199			10.5	29.1	79.0	10.1	10.5	60.8
Haryana	52	56				100.0	100.0	-	-	-
Maharashtra	161	169						-	100.0	100.0
Madhya Pradesh	68	79				50.6	100.0			49.4
Rajasthan	56	59				100.0	100.0			
Uttar Pradesh	302	285			-	24.6	100.0	28.0	-	47.4
Himachal Pradesh:										
Punjab and Chandigarh	69	36	-	41.7	66.7	58.3	33.3	-	-	-
West Bengal, Assam, Tripura, Mizoram, Meghalaya, and Manipur	121	41	16.5	48.8	33.1	-	16.5	-	33.9	51.2
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	62	14					71.0	-	29.0	100.0
Total	1,374	1,230	1.5	2.9	22.8	30.7	56.8	15.8	18.9	50.6

N.B.: I - First batch of CHWs
II - Second batch of CHWs

of CHWs of both the batches which were elicited in respect of whether the manuals were received before training, during training, after training or not at all, as can be seen in Table 31. It shows the position with regard to availability of manuals to CHW before and during training period (from 1.5% to 2.9% and from 22.8% to 30.7% respectively) for the second batch as compared to first batch. Since at the time of data collection the training of the second batch was still going on, it is not possible to generalize that the community health worker did not (50.6%) receive manuals at all.

TABLE 32

PERCENTAGE DISTRIBUTION OF TRAINERS
ACCORDING TO UTILIZATION OF MANUALS

Categories of Trainers	Utilization of Manual				
	Never	Fre- quently	Occasion- ally	Can't say	Unknown no response
MO Incharge (N=95)	21.9	45.8	29.2	0.0	3.1
MO (N=47)	10.6	48.9	27.7	6.4	6.4
BEE (N=75)	10.7	48.0	37.3	1.3	2.7
SI/HI/LHV (N=148)	20.9	37.2	37.2	2.7	2.0
Unknown (N=4)	0.0	0.0	66.7	33.3	0.0
Total (N=369)	17.6	42.9	34.1	2.4	3.0

Training process

a. Duration: The guidelines laid down by the Government of India in respect of duration of training for Community Health Workers envisage 200 hours of training, spread over a period of three months. Out of these 200 hours, class-room teaching and practical and field work are envisaged to be 92 and 108 hours respectively.

TABLE 33

DURATION OF TRAINING AND NUMBER OF DAYS PER WEEK TRAINING IMPARTED - STATEWISE

Item of Information Group of States	Total duration of training (weeks)		Number of day per week	
	Class-room training	Field training	Total Training	
	A	B	B	B
Andhra Pradesh	9.2	7.0	3.9	4.1
Bihar	11.5	6.6	2.1	4.8
Gujarat	10.8	7.6	2.9	4.1
Haryana	8.3	5.6	1.4	4.0
Maharashtra	8.9	7.7	4.1	4.3
Madhya Pradesh	8.5	6.9	1.6	4.1
Rajasthan	11.7	7.2	1.8	4.3
Uttar Pradesh	10.3	7.3	3.2	4.5
Himachal Pradesh, Punjab and Chandigarh	10.3	6.5	1.7	4.0
Uttar Pradesh, Assam, Tripura, Mizoram, Meghalaya and Manipur	10.6	8.3	2.0	5.4
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	8.5	7.3	2.5	5.8
Total	9.9	7.2	2.5	4.4

A = Data from PHC

B = Responses of CHWs

The duration of class-room training, field training and number of days in a week on which training was imparted are presented in Table 33.

The difference in the figures of average duration of class-room training obtained from the data at PHC level (9.9 weeks) and from the Community Health Worker (7.2 weeks) may be indicative of what was planned and what was finally imparted. The total duration of training as reported by CHWs worked out to 9.7 weeks on an average (class-room 7.2 weeks practical training and field training 2.5 weeks).

Though inter-State variation in the duration of class-room training, whether obtained from PHC data or from CHW is not much, yet it is quite substantial so far the field training is concerned; the range being 1.4 weeks in Haryana to 4.1 weeks in Maharashtra.

As far as the average number of days per week for the entire training is concerned, it is found to be 4.4 weeks and the range being 4.0 to 5.8 weeks.

The opinion of CHWs and the trainers was sought to determine the adequacy of duration of training. Two hundred CHWs (66.6%) out of a total of 299, felt that the duration was adequate, the percentage in MPW and Non-MPW PHCs being 72.1, 58.1 respectively. The difference in training between MPW and Non-MPW was also apparent in so far as field training was concerned; 39.3 per cent of CHWs in MPW-PHCs as compared to 16.9 per cent of CHWs in Non-MPW PHCs had field training of more than 26 days. The distribution of trainers according to their opinion on adequacy of duration of training presented in Table 34 shows that 63.2 per cent of all trainers felt that the duration was adequate. There was not much variation in responses of MO-incharge PHC, BEE and SI/HI/LHV. However, a lesser number of other MOs (57.4%) viewed the training period to be adequate.

b. Coverage of systems of medicine: The guidelines laid down envisaged flexibility in regard to the coverage of various systems of medicine during the training of CHWs. Accordingly, an attempt was made to obtain information on the number of CHW

TABLE 34

PERCENTAGE DISTRIBUTION OF TRAINERS ACCORDING TO
THEIR OPINION ABOUT ADEQUACY OF TRAINING PERIOD

Respondents	Training period			
	Not adequate	Adequate	Can't say	Unknown no resp
MO Incharge (N=95)	34.3	63.5	1.1	1.1
MO (N=47)	40.5	57.4	2.1	-
BEE (N=75)	32.0	64.0	4.0	-
SI/HI/LHV (N=148)	33.1	64.9	0.7	1.3
Unknown (N=4)	33.4	33.3	33.3	-
Total (N=369)	34.1	63.2	1.9	0.8

TABLE 35

PERCENTAGE OF CHW TRAINING COURSES IN WHICH
VARIOUS SYSTEMS OF MEDICINE WERE COVERED

Systems of Medicine	Percentage of CHWs' training course
Allopathic	100.0
Ayurvedic	64.3
Homoeopathic	28.4
Unani	30.6
Siddha	26.7

training courses where each system of medicine was covered and the views of trainers regarding adequacy of coverage of different systems of medicine.

The coverage of different systems of medicine in CHWs' training courses is given in Table 35.

So far the adequacy of coverage of various systems of medicine is concerned, 79.2 per cent of trainers felt that Allopathic and Ayurvedic systems respectively were covered adequately. The inter-State variations in respect of adequacy of coverage of different systems of medicine are apparent for all the systems of medicine (Appendix VI(b)). Rajasthan and Gujarat have higher degree of adequacy of coverage of Ayurvedic system of medicine. The discrepancies in the coverage of different systems of medicine, preference of community for a particular system of medicine and the system of medicine practised by the newly appointed third medical officer in PHC were existed. Even though community's preference, by and large, was for Allopathic system and no Ayurvedic doctor was appointed in Haryana, Madhya Pradesh and Rajasthan, yet the Ayurvedic system of medicine was covered in the training course of CHWs. This presumably might have been done through Ayurvedic doctors in public or private sectors in these States.

c. Course contents: About 66 per cent and 19 per cent of trainers felt that the contents of the course were adequate and very adequate respectively. However, only 10 per cent of trainers who felt that the course contents of CHW training were not adequate.

d. Training methods: Lectures, Demonstrations, Discussions and Supervised field experience were the various methods utilised for imparting training to CHWs.

The percentage distribution of trainers according to the degree of utilization of various training methods is shown in Table 36.

TABLE 36

PERCENTAGE DISTRIBUTION OF TRAINERS ACCORDING TO THE
DEGREE OF UTILIZATION OF VARIOUS TRAINING METHODS

Training Method	Degree of Utilization of Training Methods				Total (N=369)
	Never	Frequently	Occasionally	Can't say	
Lecture	0.8	87.8	7.0	4.4	100.0
Demonstration	3.0	41.7	50.7	4.6	100.0
Discussion	3.0	50.7	41.7	4.6	100.0
Supervised Field Experience	3.3	32.5	58.8	5.4	100.0

Whereas preference for lecture methods in terms of its most frequent usage as compared to others is apparent, yet no consistent trend was observed when the information was analysed by category of trainers.

In any training course in which transfer of skills is being attempted at, sufficient emphasis on field training is essential. Supervised field experience as a training method was utilized frequently by 32.5 per cent, and occasionally by another 58.8 per cent of trainers. In all, 75.6 per cent of such field training was in the area of environmental sanitation, including chlorination of wells and construction of latrines (22.8%), family planning (11.4%), smallpox vaccination (9.9%), immunization of children (10.5%), collection of blood smears for Malaria (13.5%), health education (5%) and MCH work (2.3%).

e. Trainees' progress: In a training programme, where basic qualifications or educational level of trainees is not uniform, it would be difficult for the trainers as well as the trainees to maintain a particular level of pace with regard to training. As such, it is vitally important to know the number

of CHW trainees who could not keep pace with the training programme. This information in terms of distribution of trainers by number of trainees who could not keep pace with the training is given in Table 37.

It is seen that 36.8 per cent of trainers mentioned that all the trainees could keep pace with the training programme (MO-incharge 33.3%, MO 29.8%, BEE 36% and SI/HI/LHV 42.5%). About 12.3 per cent trainers stated that seven or more trainees from their batches were unable to keep pace with the training programme. Model value of these trainees was two for each batch.

TABLE 37

PERCENTAGE DISTRIBUTION OF TRAINERS BY NUMBER OF
TRAINEES WHO COULD NOT KEEP PACE WITH CHW TRAINING

Number of trainees who could not keep pace	Percentage trainers (N = 369)
None	36.8
1	7.8
2	14.1
3	4.6
4	7.9
5	5.2
6	2.4
7 +	12.3
Unknown	8.9
Total	100.0

In this connection, it would be even more important to know if, any action was taken to tackle the situation, and, if so, what action was taken. The information on the same is presented in Table 38.

TABLE 38

PERCENTAGE DISTRIBUTION OF TRAINERS ACCORDING TO ACTIONS TAKEN FOR THE CHW NOT KEEPING PACE WITH TRAINING PROGRAMME, AS REPORTED BY TRAINERS

Category of trainer	Reported action taken by trainers				
	No action	Extra classes	Removal of CHW from training	CHW left himself	Report to Supervisors
MO Incharge (N=95)	10.9	81.8	0.0	7.3	0.0
MO (N=47)	14.3	64.3	10.7	7.1	3.6
BEE (N=75)	19.6	76.1	4.3	0.0	0.0
SI/HI/LHV (N=148)	16.0	80.0	4.0	0.0	0.0
Unknown (N=4)	50.0	50.0	0.0	0.0	0.0
Total (N=369)	15.6	77.2	3.8	2.9	0.5

It may be observed that no action was taken by 15.6 per cent of trainers while 77.2 per cent of trainers took extra classes which is an extremely healthy sign.

Training achievements

As stated earlier the evaluative effort was limited to an assessment of the area of knowledge only. To get an idea as to how much improvement in knowledge has taken place as a result of training, the availability of pre- and post-training evaluation would have been of immense use. In the absence of this, however, an attempt was made to assess the improvement in knowledge through administration of questionnaires containing multiple choice items and giving scores to responses. The questions related to the areas of actions required to prevent deaths, tackling certain diseases and physiological conditions and managing emergency conditions, the stage when a patient with certain symptoms needs to be referred, and knowledge of use of certain specified drugs. The responses are presented in Tables 39 to 44.

Table 39 shows the performance score of the CHWs in tackling certain symptoms in different ages and physiological conditions. Only 45.2 per cent of the CHWs could give correct answer. Another 12.2 per cent could give partly correct answer namely, that they could name the correct drug but not the correct dose. About 42 per cent could neither name the correct drug or the dose, nor any other form of correct management. This finding is not very encouraging.

Tables 40 and 41 indicate the correct responses scored by CHW in managing certain diseases and emergency conditions. In both the areas majority scored between one to three (88.5% in treating diseases and 87.5% in managing medical emergencies). This finding can be said to be satisfactory, judging from the educational background of the trainees and the duration of training.

Table 42 summarises their scores on preventive actions suggested by CHWs for preventing deaths of infants and deaths from water-borne diseases in a community. Out of five maximum points, majority scored two (38.5%) both for infant deaths and deaths from water-borne diseases.

TABLE 39

PERCENTAGE DISTRIBUTION OF CHWs WITH REGARD TO THEIR
PERFORMANCE SCORES IN RELATION TO TACKLING CERTAIN
SYMPTOMS AND PHYSIOLOGICAL CONDITIONS

Symptoms	(N=299)		
	Both (Medicine and dose) wrong	Both correct	Medicine correct but dose is wrong
Three years old child suffering from Malaria	15.4	55.8	28.8
Twenty years old man suffering from fever and headache	69.6	25.4	5.0
Forty years old man suffering from fever and headache	33.8	52.5	13.7
Six months old baby having loose motions	46.8	41.5	11.7
Pain in abdomen in a full term pregnant woman	47.5	50.8	1.7
Total	42.6	45.2	12.2

TABLE 40

PERCENTAGE DISTRIBUTION OF CHWs ACCORDING TO THE
SCORES OBTAINED BY THEM WITH RESPECT TO
REFERRAL SERVICES FOR THE PATIENTS

Disease	No. of scores obtained by CHW						(N=299)	
	0	1	2	3	4	5	Inappli- cable	Unknown No Resps.
Cough and cold	3.3	27.1	36.2	24.5	7.0	0.3	0.3	1.3
Loose motion	3.0	22.7	37.4	26.7	8.5	0.7	0.7	0.3
Vomiting	3.3	27.1	36.8	19.4	12.0	0.3	1.1	-
Earache	4.7	35.1	34.8	20.7	3.0	0.7	1.0	-
Fever	2.7	29.1	42.2	22.7	2.3	-	1.0	-
Total	3.5	28.2	37.5	22.8	6.5	0.4	0.8	0.3

TABLE 41

PERCENTAGE DISTRIBUTION OF CHWs ACCORDING TO THE
SCORES OBTAINED BY THEM WITH RESPECT TO
MANAGING EMERGENCIES

Emergencies	No. of scores obtained by CHW						(N=299)	
	0	1	2	3	4	5	Inappli- cable	Unknown No resps
Dog Bite	1.0	18.7	51.2	27.1	1.7	-	-	0.3
Electric Shock	4.3	10.7	29.8	29.8	20.1	0.3	0.7	4.3
Drowning	2.3	8.4	38.5	48.2	2.0	0.3	-	0.3
Total	2.6	12.6	39.9	35.0	7.9	0.2	0.2	1.6

TABLE 42

PERCENTAGE DISTRIBUTION OF CHWs ACCORDING TO THE SCORES
OBTAINED WITH REFERENCE TO PREVENTING DEATHS IN
INFANTS AND DEATHS FROM WATER-BORNE DISEASES

Type of Disease	No. of scores obtained by CHW						(N=299) Unknown No resps.
	0	1	2	3	4	5	
Death below one year	1.3	17.7	38.5	28.1	12.0	1.7	0.7
Death from water-borne diseases	1.3	15.7	38.5	32.5	11.0	0.3	0.7
Total	1.3	16.7	38.5	30.3	11.5	1.0	0.7

Table 43 shows their performances in specific areas namely, malaria, immunization, control of communicable diseases, nutrition, family welfare planning and drinking water supply. Pattern of scoring remained the same, namely that the majority scored between two to three.

Table 44 shows the consolidated performance of CHWs regarding their knowledge on uses of certain specific drugs from each system of medicine. Findings are very disappointing particularly in Homoeopathic, Ayurvedic, Unani and Siddha systems of medicine. Between 97.1 per cent to 99.9 per cent of CHWs had no knowledge of the drugs in these systems. The position was a little better with regard to Allopathic medicines where 50.2 per cent of CHWs had correct knowledge of the drugs. This finding was expected as hardly few PHCs had given training in other systems of medicine except Allopathic system.

TABLE 43

PERCENTAGE DISTRIBUTION OF CHWs ACCORDING TO THE SCORES
OBTAINED IN RELATION TO TACKLING CERTAIN DISEASES

Type of case	No. of scores obtained by CHWs					Unknown No resps
	0	2	3	4	5	
Malaria	6.7	20.4	36.8	27.1	9.0	-
Immunization	1.1	16.1	54.8	23.4	1.3	3.3
Communicable diseases	0.7	11.4	31.1	38.1	17.7	1.0
Nutrition	3.0	30.8	37.1	18.1	8.0	3.0
Family planning	1.7	14.4	33.8	34.1	13.3	2.7
Drinking water	1.0	25.4	65.9	7.0	0.3	
Total	2.3	19.7	43.3	24.6	8.3	1.8

TABLE 44

PERCENTAGE DISTRIBUTION OF CHWs IN RELATION TO THEIR CONSOLI-
DATED PERFORMANCE REGARDING THEIR KNOWLEDGE ON USE OF
SPECIFIC DRUGS OF DIFFERENT SYSTEMS OF MEDICINES

System of Medicine	Do not know	Partially correct	Fully correct
Allopathic (N=897)	48.5	1.3	50.2
Homoeopathic (N=1495)	99.9	-	0.1
Ayurvedic (N=495)	97.1	0.1	2.8
Unani (N=1495)	99.8	-	0.2
Siddha (N=1495)	99.9	0.1	-

The knowledge gained may be closely related to or dependent upon the basic qualification or educational level of CHW. Hence, an attempt was made to find out the average score of knowledge of CHW in a State and related it to average years of schooling of CHW in that State. The same is presented in Table 45. No definite relationship or trend can be seen. The findings with regard to assessment of improvement in knowledge as a result of training clearly establish, the need for effecting improvements in training programme in future and for refresher courses for the already trained CHWs.

Satisfaction with training and need for refresher course

Having explored the status with regard to various dimensions of training, it would be desirable to determine whether the trainers were satisfied with the training provided to CHWs. The responses of trainers indicated that 81.5 per cent of trainers (MO-incharge PHC 83.3%, other MO 76.6%, BEE 74.7%, SI/HI/LHV 85.1%) were satisfied with the training imparted to CHWs, while 14.6 per cent were not satisfied.

Further 77 per cent of trainers felt the need for refresher course.

Difficulties

Lastly, an attempt was made to identify the magnitude of difficulties faced in training as perceived by State and District level officials.

Out of the 26 responses from State level officials, ten related to inadequacy of training and/or late or non-supply of training materials, six related to inadequacy of physical facilities, four to inadequacy of staff/trained staff or transfer of trained staff and six responses related to various other difficulties.

TABLE 45

PERCENTAGE DISTRIBUTION OF CHWs ACCORDING TO NUMBER OF YEARS
OF SCHOOLING AND PERFORMANCE SCORES OBTAINED IN DIFFERENT
AREAS OF FUNCTIONING OF CHW - STATEWISE

States	Years of Schooling	B (Max. 5.0)	B (Max. 4.8)	E (Max. 4.5)	F (Max. 5.0)	C (Max. 4.3)	A (Max. 5.0)
Andhra Pradesh	8.53	2.01	1.68	2.00	0.038	1.89	0.31
Bihar	10.33	2.83	2.57	2.35	0.054	2.86	0.54
Gujarat	8.40	2.49	2.13	2.37	0.066	2.27	0.56
Haryana	8.75	2.08	2.02	2.19	0.107	2.53	0.66
Maharashtra	7.65	2.26	1.94	2.46	0.035	2.39	0.49
Madhya Pradesh	9.19	2.34	2.05	2.30	0.096	2.31	0.57
Rajasthan	8.25	2.58	1.98	2.29	0.036	2.19	0.45
Uttar Pradesh	9.80	2.43	2.02	2.54	0.094	2.29	0.61
Himachal Pradesh, Punjab and Chandigarh	7.69	2.53	2.29	2.55	0.084	2.89	0.51
West Bengal, Assam, Tripura, Mizoram, Meghalaya and Manipur	8.65	2.29	1.85	2.28	0.090	2.21	0.50
Orissa, Sikkim, Goa, Daman & Diu, and Pondicherry	8.00	2.34	2.30	2.36	0.047	1.98	0.53

Connotations:

A = Services provided to reduce certain mortalities.

B = Conditions/Symptoms for referral of patients.

C = Measures in relation to certain communicable diseases, and health programmes.

D = Use of certain medicines from various systems.

E = How to deal with certain emergencies?

F = Name and dose of medicines in respect of certain diseases/conditions.

As far as the District level officials are concerned, out of the 66 responses, 21 related to inadequacy of staff/ trained staff or transfer of trained staff, six related to course content (being too difficult to be understood by CHW), 12 related to inadequate physical facilities, seven related to inadequacy of audio-visual aids and other training materials, and 20 respondents had difficulties of other nature.

The nature and range of other difficulties perceived at State and District levels covered the following:

1. training was not uniform in all blocks;
2. non-payment of stipend during the training programme;
3. paucity of POL for field training;
4. training in respect of manual was difficult;
5. government instructions were not clear;
6. third medical officer was yet to be appointed;
7. inadequacy of finance; and
8. inadequacy of clerical staff.

CHAPTER VII

ADMINISTRATION AND LOGISTICS

A programme, howsoever, well planned, is largely depend on its administration in terms of procurement of right type of resources required at the right time in right quantities and their deployment to the points of consumption. The Community Health Workers' Scheme, as formulated by the Government of India, is only a set of guidelines, the resources that would be available for its implementation having been specified. It provides considerable flexibility for the States to develop micro level plans and implement the same with whatever modifications considered fit in the best interests of its implementation. A number of resources, as inputs to the Scheme, have been provided for, namely,

- i. training of the selected CHWs;
- ii. providing medicines worth Rs.50 per month per CHW;
- iii. payment of an honorarium of Rs.50 per month per CHW;
and
- iv. appointment of a third medical officer.

Training of the selected CHWs including supply of manual, is evaluated and discussed in a separate Chapter. This Chapter attempts to evaluate the other three inputs and to identify problems and difficulties in their procurement and deployment. In addition, maintenance of records by CHWs and certain other related issues were also discussed, though this is not a direct input to the Scheme.

Supply of medicines ✓

An important input is the supply of medicines to the CHW. In evaluating this input a number of questions have been considered. These were:

- a. is the medicine kit supplied and when?
- b. what medicines, as per the list provided by the Government of India, are actually supplied by different States to their Primary Health Centres?
- c. out of the medicines supplied: (i) what medicines are used most? (ii) what medicines are not at all used?; and (iii) what medicines are in short supply?
- d. are the staff members of PHCs facing any difficulty in the supply of medicines? If so, what difficulties?
- e. are Panchayats prepared to contribute in case of shortage of medicines?

The information about the supply of kits was ascertained from each of the sampled PHCs, separately for the first and the second batches. The results are summarized in Table 46. It may be observed that large majority of CHWs of first batch (82.4%) received their kits after the training was over. As many as 10.7 per cent of them were yet to receive their kits. The status of the second batch of CHWs was worse. About two-thirds of them did not receive their kits. As a whole,

TABLE 46

SUPPLY OF MEDICINE KITS

Medicine kits were supplied	I Batch	II Batch	All CHWs
During training	94(6.9)	44(3.5)	138(6.3)
After training	112(82.4)	293(23.6)	1414(54.3)
Not yet supplied	145(10.7)	844(47.8)	989(38.0)
No response	-	63(5.1)	63(2.4)
Total	1360(100)	1244(100)	2604(100)

(Figures in parentheses are percentages)

though about 60 per cent of them stated to have received the kits yet 38 per cent of them were awaiting the same.

Most of the States except Andhra Pradesh, Maharashtra, Punjab, Sikkim and Mizoram followed the list of medicines suggested by the Government of India without any changes. The other States reported to have made some changes due to reasons given below:

- a. medicines should suit the local morbidity conditions;
- b. availability of substitute in the local market; and
- c. help reduce the number of items in the list which was long.

These reasons appeared to be fairly reasonable so long as the modified list meets the local needs.

The status of actual supply of medicines to Primary Health Centres was in an awful condition, as can be seen from Appendix VII(a). Out of 20 medicines to be supplied to them only eight were supplied, that too in 50 to 60 per cent of PHCs as summarized in Table 47. One or the other of the

TABLE 47

MEDICINES RECEIVED BY PHCs

Medicine	% PHCs Received
1. Eye and Ear drops	67.6
2. Benzyl Benzoate emulsion	66.2
3. Mag. hydroxide (Tab.)	60.8
4. Chloroquin (Tab.)	58.1
5. Kaolin powder	58.1
6. Mercurochrome (2%)	58.1
7. Cough Mixture	56.8

remaining 12 medicines was received by very few Primary Health Centres. Interestingly enough, Homoeopathic medicines were received by only 6.8 per cent of PHCs whereas Siddha medicines were received by only 1.4 per cent of them. Ayurvedic medicines were, however, received by as many as 16.2 per cent.

Substantial Inter-State variations were found in the supply of medicines. Table 48 shows the extent of supply of medicines to PHCs. In Maharashtra, out of the list of 20, only four were supplied. These were APC tablets (50%), Chloroquin tablets (60%), Homoeopathic medicines (20%) and Ayurvedic medicines (20%). Even these four were made available to few PHCs as can be seen from percentages in brackets. Uttar Pradesh presents an entirely opposite picture. In this State, though all medicines in the list were covered, yet the coverage of PHCs was poor. Remaining States fall in between these two extremes.

TABLE 48

EXTENT OF SUPPLY AND COVERAGE OF PHCs - STATEWISE

States	No. of medicines supplied	No. of medicines supplied to				
		100% PHCs	75-99% PHCs	50-74% PHCs	25-49% PHCs	Less than 25%
Andhra Pradesh	8	2	-	1	3	2
Bihar	7	6	-	-	1	-
Gujarat	12	-	7	-	-	5
Haryana	10	7	-	2	1	-
Maharashtra	4	-	-	2	-	2
Madhya Pradesh	17	6	7	3	1	-
Rajasthan	13	5	-	5	3	-
Uttar Pradesh	20	-	1	5	6	8

Another interesting result that emerges from this analysis is that while Siddha medicines were supplied in only one State (that too, to a few PHCs), Ayurvedic medicines were supplied in five States and Homoeopathic medicines in three States only. Thus, the coverage of States and PHCs in the States is poor as far as these medicines are concerned.

The sample of CHWs drawn was asked to indicate the medicines mostly used by them. While the response pattern was generally scanty, nine medicines, namely, Paracetamol, Magnesium Hydroxide, Cough mixture, Chloroquin, eye drops, APC, Mercurochrome, Benzyl Benzoate, Kaolin powder were reported to be the most commonly used by a fairly large number of CHWs. Details are shown in Appendix VII(a).

The response pattern in the case of medicines not at all used, medicines demanded by community but not supplied, and medicines in short supply, was also scanty. This could particularly be attributable to the fact that the CHWs were initiated into health work barely a couple of months ago. The time duration was so short that they might not have had an opportunity to use each of the medicines atleast once. It can be seen, however, that a simple medicine like APC was reported to be in demand but that itself was in short supply. Under such circumstances, the availability of other medicines is absolutely doubtful.

A number of staff members working in the sampled PHCs such as Medical Officers, BEEs and Sanitary Inspectors were interviewed to find out whether they were facing any difficulty in the supply of medicines. A large majority of them stated that there was no difficulty so far as they were concerned. They reported that whatever medicines were made available to them were, in turn, supplied to CHWs.

Another interesting aspect relates to the bridging of the gap between the demand for and supply of medicines. The CHWs were asked whether their Panchayats would contribute to get more medicines, and if yes, have they contributed? The responses to these two questions are presented in Appendix VII(b).

Though 64.9 per cent of CHWs stated that their village Panchayats will not contribute, yet another 15 per cent stated

that they would contribute. Considerable inter-State variations existed in the pattern of response to this question. In Haryana and Rajasthan, as many as 41.7 per cent stated that they would contribute the medicines. In the remaining States, it varied between 6 per cent to 25 per cent.

The actual contribution to buy more medicines by Panchayats was of a very small magnitude, though such experience was reported from Maharashtra, Rajasthan and Orissa.

Records

Maintenance of records by Community Health Worker, though not an input for the programme, is however, important for evaluation of programme performance, as well as an instrument for programme administration, particularly for its monitoring. The policy decision taken by the Government of India clearly specifies that they would not be asked to maintain any records and would not be expected to submit any reports. It was felt that it might lead to interference by the governmental machinery in the functioning of CHW. This being a decision at the National level, how is it being actually implemented? In this regard, three aspects were examined, namely,

- a. is the CHW maintaining records?
- b. if so, what records does he maintain?
- c. is he maintaining these records at his own discretion or under the advice of someone? If so, under whose advice?

Out of a total of 299 CHWs interviewed, 259 (86.6%) stated that they were maintaining one or the other records. Inter-State variations are also quite apparent. While over 90 per cent of the CHWs in majority of the States are maintaining the records, their percentage in Bihar, Maharashtra and Rajasthan is found to be 50, 55 and 58.3 respectively. The details of the same can be found in Appendix VII(c).

An inventory of records being maintained by one or the other of CHWs indicated that there was a total of 13 such records. The percentage distribution of CHWs maintaining these records out of the 259 is given in Table 49.

TABLE 49
PERCENTAGE DISTRIBUTION OF CHWs
MAINTAINING DIFFERENT RECORDS

Type of Record	% CHWs maintaining
Medicine stock	81.5
Vital events	44.8
Daily diary	35.1
Patient register	32.0
Family planning records	26.3
Malaria cases	29.0
Immunization	12.7
Household survey	10.0
MCH register	7.3
Chlorination of wells	51.4
Records of meetings held	5.4
Others	18.5

Inter-State variations are found to exist on this dimension. A register to maintain the stock of medicines is the most commonly used record in all the States, followed by: (a) daily diary in four States, namely, Andhra Pradesh, Maharashtra, Bihar and Haryana; and (b) a register for vital events in all others except Rajasthan where the second most commonly used record is of patient register and register for malaria cases.

Thus, it can be said that register for stock of medicines daily diary, register for vital events, register for malaria cases, happened to be the most commonly used records in different States.

Among the 299 CHWs interviewed, 285 (95.3%) stated that they were asked to maintain these records. This percentage remained more or less the same in different States where it was found to be varying between 90 to 100. As a part of training imparted to CHWs, they were advised by the PHC staff to maintain certain records, the percentage of which, however, varied from State to State.

Honorarium

The Scheme provides for payment of an honorarium of Rs.50 per month per CHW. A sample of CHWs, village leaders, BDOs etc. were interviewed to get their views on two aspects; namely, whether the CHWs were getting their honorarium regularly and whether they were satisfied with the amount.

A large majority of the CHWs reported that considerable delays occur in getting their honorarium. They were not happy with the amount particularly because during their training they received Rs.200 per month which dwindled to Rs.50 as soon as the training was over. It is quite natural, however, that the CHW should report about inadequacy of the amount.

The adequacy or otherwise of the same was, therefore, enquired from others also such as village leaders, BDOs and Zila Parishad Presidents/Members. The response pattern is presented in Appendix VII(d). It may be observed that only 166 (23.1%) of the 719 stated that it was not sufficient. On further probing, it was found that the modal value of the honorarium suggested by them was Rs.100.

The response pattern was found to be generally uniform in all the States on these dimensions.

Recruitment

The CHW Scheme provides for the appointment of a third medical officer in each of the Primary Health Centre imple-

menting the Scheme. An attempt was made to ascertain from the State Officials about the number of such posts created, number filled and wherever filled the nature of the system to which this third medical officer belonged.

It was found that the creation and filling up of the post of the third medical officer was done only in a few States, namely, Andhra Pradesh, Gujarat, Uttar Pradesh, Eastern States and certain Union Territories. In all the other major States, the post has not yet been created.

The posts of third medical officer were created in 412 PHCs, out of which 331 (80.3%) have since been filled up. The inter-State variations on this dimension are quite apparent from Appendices VII(e) and VII(f). While 95.8 per cent of the posts are reported to have been filled up in Andhra Pradesh, followed by Uttar Pradesh (94.5%), whereas the same was 49.5 per cent in Gujarat and 40.4 per cent in Eastern States.

Another interesting feature that emerges is about the background of the third medical officer. While 32.5 per cent belonged to Ayurveda, and 11.4 per cent to Unani, the other systems namely, Homoeopathy and Siddha are found to be completely absent.

The variations between different States with respect to the background of the third medical officer are quite significant. While all the posts in Andhra Pradesh and Eastern States were filled up by doctors of modern system of medicine, whereas the same posts were reported to have been filled up in Uttar Pradesh by doctors of Ayurveda and Unani.

The difficulty most commonly reported for not filling up the posts was of administrative delays.

CHAPTER VIII

PERFORMANCE OF COMMUNITY HEALTH WORKERS

This Chapter on Performance of Community Health Workers is a crucial one in that it provides an idea about the work being performed by CHW and whether he/she is capable of handling the various types of activities expected to be performed by them.

It may be mentioned here that there were some basic limitations under which the evaluation of performance is undertaken. These are:

- a. evaluation of performance, by and large, has to be based on certain measurable indicators worked out on the basis of either retrospective or prospective data. The Community Health Workers, however, are not required to maintain any record. In the absence of any such records, the performance evaluation was attempted to be based on indirect and qualitative data obtained from reported impressions about the performance of the CHW in the field; and
- b. the performance evaluation necessarily requires that the scheme is on the ground for a reasonably long time before such an attempt is made. In the present case, however, the activities undertaken by the CHWs within the previous two months were taken into consideration because the first batch of CHWs was in field in January 1978. Naturally, the responses of different levels of people are based on very limited experience with or exposure to the CHWs in the field.

Keeping these two constraints in view, an attempt has been made to answer some of the following questions which reflect the performance of Community Health Worker:

- a. what are the views of the Community Health Workers about the actual time spent by them on health activities per day in the community?
- b. what are the views of other members of the community regarding the adequacy or otherwise of the time that the CHWs spent for health work?
- c. what are the different types of purposes and the frequency of contacts of community members with the CHW?
- d. what are the different types of activities and levels of assistance being provided by Community Health Worker to different categories of personnel of the PHCs and *vice versa*? and
- e. what is the level of overall satisfaction of community members about the performance of Community Health Workers in the village? /

According to the Scheme, CHW is expected to spend about two to three hours daily on health activities. About 59 per cent of CHWs claimed that they have been spending the suggested hours of time, *i.e.* two-three hours daily. About 25 per cent of them are spending between four-five hours a day for the purpose of providing health care to the community. Further, 6.7 per cent CHWs spent more than five hours while 4.0 per cent spent less than two hours per day. Non-response was to a tune of 5.3 per cent.

The CHWs were further asked to specify the time of the day that has been earmarked by them for providing services to the community. It was found that 39.8 per cent of them utilized morning hours for this purpose, while 17.4 per cent of them had no fixed timings. Another 23.1 per cent stated that they utilized both morning as well as evening timings for the purposes of undertaking health work. Statewise variations are found to exist on this dimension. In Andhra Pradesh (75%), Haryana (50%), Maharashtra (45%) and Uttar Pradesh (42.3%), the CHWs utilized 'mostly morning hours' for providing the services to the community. However, 'no fixed timings' was reported in Bihar (41.7%), Madhya Pradesh (37.5%), Rajasthan (50.6%), Punjab and Himachal Pradesh (37.5%) as shown in Appendix VIII(a).

The Community members were also asked about the availability of the health workers in the village. About 58 per cent of them stated that the Community Health Worker was available all the time, whereas 8.4 per cent stated that he was available for health work during fixed hours only. No significant inter-State variations, however, were observed.

In order to validate the estimates given by CHW about the time he spent on health activities, different levels of people living in the community as well as those associated with the implementation of the scheme were asked to express their views on adequacy or otherwise of the time devoted by Community Health Worker towards the health care in the community. Table 50 depicts the views of these people about the statement.

TABLE 50

PERCENTAGE DISTRIBUTION OF DIFFERENT RESPONDENTS
ACCORDING TO THEIR VIEWS WITH REGARD TO THE
ADEQUACY OF TIME SPENT BY CHW ON HEALTH WORK

Category of respondents	Time spent by CHW on health			
	Not adequate	Adequate	Can't say	Unknown
CHW (N=299)	24.7	68.9	3.0	3.3
Community Leaders (N=604)	23.3	72.6	3.3	0.6
VLW (N=203)	34.9	57.6	3.4	3.9
BDO (N=73)	35.6	61.6	2.7	-
Zila Parishad Presidents/Members (N=42)	28.5	69.0	2.3	-
All categories (N=1221)	26.5	68.4	3.1	1.8

On an average, 68.4 per cent of the respondents stated that the time spent by the CHW on health work was adequate. Only 26.5 per cent of them felt otherwise. In case of Eastern States (West Bengal, Assam, Tripura, Meghalaya and Manipur) only 33.6 per cent of BDOs stated that the time spent by Community Health Worker on health activities was adequate. In Orissa, Sikkim, Goa, Daman & Diu and Pondicherry together 50 per cent of the Community Health Workers claimed that the time spent by them on health activities was adequate. While certain Statewise variations existed in a large majority of the respondents; namely, Community Health Workers, Community Leaders, VLWs, BDOs and Zila Parishad Presidents/Members reported adequacy of the time spent by the Community Health Worker. The details are shown in Appendix VIII(b). Thus, it can be observed that there is consistency in the responses of CHW and other members of community in relation to the time spent by CHW in the community.

An attempt was made to assess the frequency of contacts between the CHW and the community members. The major purposes of such contacts were also investigated. Of the 6,013 community members interviewed, 60 per cent had contacted the CHW for one purpose or the other. The rest of them did not contact the CHW. It was further seen that about 61.2 per cent of the community members contacted Community Health Worker for only one purpose, whereas the remaining 38.8 per cent contacted the CHW for two to three purposes. Interestingly, out of the total contacts made, a CHW has been approached by a community member on an average 2.48 times during his two months period of operation in the community. The Statewise variations are shown in Appendix VIII(c).

The analysis of the exact purpose for which the Community Health Worker was approached related to preventive as well as curative health services. Table 51 provides the distribution of community members by purpose for which they contacted CHWs. It can be seen that the purposes for which the CHW has been approached are almost in tune with the training provided in curative and preventive health services. Except in the case of immunization (2.6% of community members), all the rest of them approached for curative services. Though the responses are in the context of experience of two months only, yet it gives a fairly good idea of pre-occupation of CHW with curative services. The purposes for which the community members

contacted the Community Health Worker do not show large inter-State variations. However, fevers constitute the single condition occupying the first rank in all the States.

The performance of Community Health Workers was also assessed in relation to the other activities performed by them and assistance provided by them to PHC staff. In this regard, CHWs were asked to state as to how often have they conducted

TABLE 51

PERCENTAGE DISTRIBUTION OF COMMUNITY MEMBERS BY
PURPOSE FOR WHICH THEY CONTACTED CHWs

Purpose of visit	Community members who contacted CHW	
	No.	Per cent
Fever	1228	34.1
Cold/Cough	557	15.4
Dysentery	83	2.3
Headache	241	6.6
Stomach pain	161	4.4
Skin disease	189	5.2
Malaria	121	3.3
Immunization	96	2.6
Loose motions	106	2.9
Injuries	77	2.1
Eye trouble	65	1.8
Other ailments	434	12.0

group meetings, distributed printed materials and had contacted the members of the community. All these activities were expected to help increase the utilization of the PHC and motivate the community members towards better health practices.

Table 52 shows that 67.2 per cent of the CHWs had 'mostly' contacted the community members individually. About 39 per cent of these CHWs stated that they sometimes organized group meetings, whereas 34.8 per cent also confirmed that they distributed printed materials sometimes. Though the individual contacts 'mostly or sometimes' had been undertaken by Community Health Workers in all the States, yet there are variations in undertaking the group meetings and the distribution of printed materials to the community. In case of Maharashtra, only 12.5 per cent Community Health Workers stated that they were responsible for undertaking group meetings, whereas in case of Himachal Pradesh, Punjab and Chandigarh, only 6.2 per cent of them stated to have distributed printed materials etc., amongst the people. However, the overall assessment shows that individual contacts 'mostly' or 'sometimes' were made by 93.7 per cent of the Community Health Workers followed by group meetings by 48.2 per cent of CHWs. Further, details of the same can be seen from Appendix VIII(d).

In terms of the assistance provided for arranging mass meetings, film shows, exhibitions, service camps etc., CHWs have reported that these are mostly helpful. About 45 per cent of the CHWs have rendered assistance in mass meetings

TABLE 52

PERCENTAGE DISTRIBUTION OF CHWs ACCORDING TO THE ACTIVITIES UNDERTAKEN BY THEM DURING THE LAST TWO MONTHS

Activities	Mostly	Some times	Never	Unknown
Group meetings	8.7	39.5	47.5	4.3
Distribution of printed material	5.4	34.8	55.8	4.0
Individual contacts	67.2	26.4	3.0	3.3

and 30.4 per cent of them had 'sometimes' helped in arranging such meetings. The weakest area of providing assistance by CHWs has been identified as the 'exhibitions' and also to some extent 'service camps'. Community Health Workers provided assistance 'mostly' or 'sometimes' for arranging mass meetings in Bihar (75%) followed by Rajasthan (50%) and Uttar Pradesh (49.3%) and in other States (Orissa, Sikkim, Goa, Daman & Diu and Pondicherry). The assistance for arranging film shows was provided minimum in the case of Madhya Pradesh (6.2%), Bihar (8.3%), Himachal Pradesh, Punjab and Chandigarh (12.5%), Uttar Pradesh (9.9%) and Maharashtra (2.5%) which might be due to the fact that film shows are seldom arranged. Still, weaker area of providing assistance has been the arrangements of exhibitions and service camps as reflected in Appendix VIII(d).

The relationship between the Community Health Worker and the multipurpose/unipurpose worker in the community was assessed in terms of the referral of cases. It is reported by MPWs that a total of 119 (52.9%) of them had referred cases from CHW. The actual number of referrals per CHW varied from one to twelve during the two months period per MPW/UPHW.

About 14 per cent of MPWs/UPHWs could not specify the nature of the cases referred to them. However, cases referred by CHWs were for different purposes, such as family planning advice, sterilization, fevers, vaccination/immunization, minor ailments etc.

The Community Health Workers were also asked to indicate the number of times MPW/UPHW visited them during the previous one month. It was found that 47.4 per cent of them were visited between one to two times and 26.0 per cent stated that such visits were between three to four times. However, 13.04 per cent claimed that there were no such visits. The average number of visits made by MPW/UPHW to Community Health Workers during the previous one month was reported to be about 1.4 visits. In case of Andhra Pradesh (37.5%), Gujarat (34.3%) and other States (35%) such visits have been between three to four times. Such visits extended upto ten times in Uttar Pradesh. About 33 per cent of CHWs from Eastern Zone (which includes West Bengal, Assam, Mizoram, Meghalaya and Manipur) claimed that there were no such visits by multipurpose workers.

From the point of view of overall satisfaction of the community members towards the provision of services by Community Health Worker, it was observed that 47.8 per cent of them were satisfied with their services and only 12.2 per cent reported that they were not satisfied. However, 40 per cent of the community members did not answer this question since they felt that it was too early to express satisfaction or otherwise of the work of Community Health Worker. The satisfaction rates, however, varied from State to State. About 70 per cent of community members from Bihar, 63.0 per cent from Andhra Pradesh and 54.7 per cent from Madhya Pradesh, 53.0 per cent from Uttar Pradesh and 43.9 per cent from Himachal Pradesh, Punjab and Chandigarh and 49.9 per cent from Eastern Zone reported satisfaction. Further details are shown in Appendix VIII(e).

The performance data of Community Health Workers discussed above could only be a pointer to the kind of work he/she was doing and the responses/expectations of the people. It is not possible from the evidence to clearly state whether performance of the Community Health Worker has been upto the mark in relation to the inputs that have gone into his selection, training and placement. One can only hope to assess the outcome of these inputs at a later stage when he/she is in the field for a sufficiently long time.

CHAPTER IX

ACCEPTABILITY

The Community Health Workers' Scheme is built on the philosophy of community participation and involvement. The basic pre-requisite for such an approach is its acceptability to all those concerned with it for its successful implementation. In order to study the acceptability of this Scheme at various levels, the reactions of the following groups were covered:

- a. those responsible for implementing the Scheme either directly or indirectly. This group included: on the one hand, Government officials and functionaries at the State, District, Primary Health Centre and village levels; and on the other, the formal and informal leaders of the people at the district as well as at the village level;
- b. the potential and actual beneficiaries of the Scheme. This group included the villagers for whom the Scheme was meant; and
- c. the Community Health Workers (CHW).

With a view to finding out whether this Scheme was acceptable to the above categories of respondents, several dimensions of acceptability were studied either by direct questioning or by drawing inferences on the basis of indirect evidence obtained based on the responses of those interviewed so as to find answers to the following questions:

- i. what was the general reaction to the Scheme as indicated in their opinions about the possible outcome of the Scheme?

- ii. would the respondents like the Scheme to continue?
- iii. did the health staff at the grass root levels feel that the CHW would be useful so far their own work was concerned?
- iv. what was the perception of the workers at the grass root levels with respect to the acceptability of the CHW to the community?
- v. what was the perception of formal and informal leaders as well as of officials and functionaries regarding the willingness of the community to take over financial and administrative responsibility of the CHW Scheme?
- vi. were the beneficiaries of the Scheme satisfied with the services provided?
- vii. were the financial aspects of the Scheme acceptable to the CHW?
- viii. did the CHW face any difficulty in getting acceptance from the community?

While presenting the findings pertaining to the dimensions of acceptability mentioned above, an attempt has been made in this Chapter to highlight the variations and the similarities in the responses given by different categories of respondents to the same or similar questions.

Opinion about possible outcome of the CHW Scheme

In order to assess the opinions of the respondents regarding the possible outcome of the CHW Scheme; a set of statements, both favourable and unfavourable, were presented to the respondents and they were asked to indicate whether they agreed or disagreed with the statements. A 'cannot say' category was also provided for those who could not express a firm opinion on the matter under consideration. No attempt, however, was made to study the degree of favourableness or unfavourableness by assigning scores to individual responses and then putting them on a scale. The findings are, therefore, presented separately for the favourable and unfavourable statements. Though this approach does not provide information

on the proportions of the respondents according to their degree of favourableness or unfavourableness based on their responses considered together, it provides valuable information on the opinions of various categories of respondents to specific aspects of the Scheme. This information is valuable from the point of view of programme implementation as it provides guidelines for either strengthening certain aspects of the Scheme or for taking precautionary measures to avoid undesirable consequences. The extent to which the respondents agreed with the favourable statements and disagreed with the unfavourable statements are, however, indicative of the acceptability of the Scheme to them. The findings of the same are given in Tables 53 and 54.

TABLE 53

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS, BDOs AND ZILA PARISHAD PRESIDENTS/MEMBERS ACCORDING TO THEIR REACTION TOWARDS THE CHW SCHEME

Statements	Community Leaders (N = 604)		BDOs (N = 73)		Zila Parishad Presidents/ Members (N=42)	
	Agree	Dis- agree	Agree	Dis- agree	Agree	Dis- agree
<i>Favourable</i>						
1. The CHW Scheme brings health care to the door steps of the people	94.1	2.7	87.7	2.7	78.6	11.9
2. The CHW is always available when needed	92.7	4.7	43.8	15.1	45.2	28.6
3. The CHW is competent enough to deal with health problems	74.4	12.9	35.6	41.1	35.7	52.4
4. The CHW Scheme is the answer to the health problems of rural areas	84.3	7.1	58.9	23.3	50.0	35.7

5. The neglected and poor section of the village will be looked after by the CHW Scheme	89.5	7.1	78.1	11.0	50.0	19.0
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Unfavourable

1. The CHW will become more interested in handing out medicines than in preventing diseases and promoting good health	40.6	49.2	65.8	19.2	66.7	14.3
2. The CHW will take care of only the rich in the village	8.1	87.7	12.3	79.4	26.2	52.4
3. The CHW will start thinking himself as a doctor when he is not one	27.7	58.8	60.3	24.7	69.0	16.7
4. Politically powerful persons will use the CHW Scheme to make themselves more influential	17.6	71.6	42.5	46.6	47.6	35.7
5. The other health staff will neglect the village because of the CHW Scheme	23.5	64.7	23.3	69.9	35.7	52.4

TABLE 54

PERCENTAGE DISTRIBUTION OF PHC STAFF, DISTRICT AND
STATE LEVEL OFFICIALS ACCORDING TO THEIR REACTION
TO THE POSSIBLE OUTCOMES OF CHW SCHEME

Statements	PHC staff (N = 369)		District Level (N = 142)		State Level (N = 60)	
	Agree	Dis- agree	Agree	Dis- agree	Agree	Dis- agree
<i>Favourable</i>						
1. CHWs will help to extend health services to neglected poor sections of rural society	53.1	36.8	86.6	4.9	70.0	11.7
2. CHW would provide much needed community support to rural Multipurpose Worker	28.9	59.7	76.1	11.3	66.7	13.3
3. Majority of CHWs are honest, sincere workers	13.4	79.3	28.9	12.0	28.3	13.3
4. This scheme will make the health services responsive to people's need	75.5	15.0	72.5	14.1	70.0	10.0
5. CHW will impart health education which was neglected so far	86.1	8.7	57.8	24.7	55.0	30.0
6. People will feel closer to PHC staff	67.3	20.7	73.9	14.1	71.7	15.0
7. CHW will safeguard people from quackes	58.6	27.3	29.6	38.7	25.0	40.0

8. CHW will enable early detection of certain diseases and prompt remedial actions	87.2	4.9	81.0	7.0	73.3	11.7
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Unfavourable

1. CHW will over emphasise curative functions at the cost of preventive and promotive work	7.6	84.7	48.6	28.9	45.0	30.0
2. Family planning programme is likely to suffer most under this Scheme	45.2	28.6	4.9	86.6	1.7	71.7
3. Majority of CHW will start private practice	83.7	6.0	48.6	11.3	43.3	21.7
4. The CHW Scheme will result in duplication of efforts between Multipurpose and Community Health Worker	50.7	15.5	21.8	71.8	18.3	61.7
5. CHW Scheme will harm the course of health care in rural areas	17.7	75.2	9.9	70.4	20.0	60.0
6. Only the upper strata of village society will be benefitted from this Scheme	32.2	38.4	14.8	71.1	13.3	65.0
7. Majority of the CHWs are interested in making money	17.7	63.2	21.1	28.1	25.0	25.0
8. CHWs are political leaders, they are interested in improving their political image	27.5	63.2	21.8	50.7	18.3	45.0

9. They will not do anything for other Health Scheme except distributing medicines	54.8	36.8	23.9	51.4	26.7	48.3
10. The Scheme is too expensive	22.1	43.8	21.1	28.9	-	-
11. Government can't afford to run such mini Scheme	79.3	9.3	47.9	20.4	36.7	38.4
12. CHW will eventually become mini doctor	73.8	18.3	41.6	43.0	31.7	53.3
13. If the Government find it difficult to meet the demand for medicines, this may ultimately harm the image of the PHC	81.5	13.6	47.9	20.4	56.7	26.7

While more than three-fourths of the community leaders agreed with the statements which were favourable to the CHW Scheme in general and the CHW in their specific villages in particular, whereas only two-fifths or less agreed with the statements which were unfavourable. This finding generally indicates that a higher percentage of the beneficiaries, actual and potential, viewed the Scheme in a favourable light. It can, therefore, be deduced that the Scheme was acceptable to them. Interestingly enough, one statement which was considered as unfavourable to the Scheme, by the researchers was interpreted or perceived differently by different community leaders. When asked whether they agreed or not with the statement, "the CHW will become more interested in handing out medicines than in preventing diseases and promoting good health", about 41 per cent agreed with this statement and about 50 per cent disagreed. This statement can be viewed as indicative of favourableness or unfavourableness on the part of the respondents depending upon his/her expectations of the CHW. The concepts of prevention of diseases and promotion of good health are not easily comprehended, while 'handing out

medicines' is very concrete and specific. It is, therefore, not surprising that about two-fifths of the community members interviewed also have agreed with this statement.

A clear-cut picture of whether or not the Zila Parishad Presidents/Members were favourably inclined to the Scheme did not emerge from their responses, as their reactions to favourable and unfavourable statements differed widely. For instance, 78.6 per cent of the Zila Parishad Presidents/Members agreed that "the CHW Scheme brings health care to the doorsteps of the people", and about half the number interviewed agreed that "the CHW Scheme is an answer to health problems of the rural areas", and that "the neglected and poor sections of the village will be looked after by the CHW Scheme". Only 35.1 per cent agreed with the statement that "the CHW was competent enough to deal with health problems". These Zila Parishad Presidents/Members also agreed with the negative statement about the Scheme to a much greater extent than the formal and informal leaders at the community level. This finding indicates that the Zila Parishad Presidents/Members belonging to the elite group, are able to look at the Scheme more critically. The question to be considered here is whether the opinions of the leaders at the community level or of those at the district level need to be considered as having greater relevance. It is possible that the leaders at the community level speak on the basis of their actual experience of the functioning of the Scheme, whereas those at the district level can view the Scheme at the theoretical level.

The Block Development Officer (BDO) is also concerned with the CHW Scheme as health and family welfare programmes are considered to be development programmes. His involvement, however, is not as direct as that of persons belonging to the Health Department, but he certainly has a role to play in providing supportive assistance. It was, therefore, essential to find out how far this Scheme was acceptable to the BDOs. It was found that the majority of the BDOs interviewed agreed with the positive statements concerning the theoretical assumptions of the Scheme. Illustrations of such statements are: "the CHW Scheme is an answer to the health problems of the rural areas" (58.9%); "the neglected and poor sections of the village will be looked after by the CHW Scheme" (78.1%); and "the CHW Scheme brings health care to the doorsteps of the people" (87.7%). When it came to the competence of the CHW to deal with health problems, however, only 35.6 per cent

agreed that the CHW was competent enough to do so. With regard to the negative statements, more than 60 per cent agreed that "the CHW will start thinking of himself as a doctor when he is not one" (60.3%); and "the CHW will become more interested in handing out medicines than in preventing diseases and promoting good health" (65.8%). As in the case of community leaders and Zila Parishad Presidents/Members, the majority of the BDOs did not fear either that "the CHW will take care of only the rich in the village", or that "the other health staff will neglect the village because of the Scheme".

The officials and functionaries at the Primary Health Centre (PHC), District and State levels were also presented with a set of positive and negative statements regarding the possible outcomes of the Scheme and asked to react to them. This set of statements was not identical with those presented to the Community Leaders, the Zila Parishad Presidents/Members and the Block Development Officers but was an enlarged version with some common statements. By and large, there was not much variation in the responses (Table 54) of the officials at various levels specially with reference to positive statements such as:

- a. "CHW will help to extend health services to neglected and poorer sections of society" (53.1%, 86.6% and 70.0% for PHC staff, District level officials and State level officials respectively);
- b. "the Scheme will make the health services responsive to people's needs" (75.5%, 72.5% and 70.0%);
- c. "the CHW will impart health education which was neglected so far" (86.1%, 57.8% and 55.0%); and
- d. "people will feel closer to the PHC staff" (67.3%, 73.9% and 71.7%).

On the other hand while about three-fourths of the officials at the District and State levels agreed that "the CHWs would provide much needed community support to rural Multipurpose Workers", only 28.9 per cent of the PHC staff members agreed to this statement. Here again one sees the discrepancy between the perception of those who are closely associated with the implementation of the Scheme and those

who are concerned mainly with providing direction. Another interesting finding was that while more than half the number of the PHC staff members interviewed agreed that "CHWs will safeguard people from quacks", only 29.6 per cent of the District level officials and 25.0 per cent of the State level officials thought so, thereby once again indicating a difference in perception of officials at different levels. Surprisingly enough, very few officials at all the three levels agreed that "the majority of the CHWs are honest and sincere workers" (PHC staff 13.4%, District level 28.9% and State level 28.3%).

One of the fears expressed by the medical community all over the country is that these CHWs would consider themselves to be doctors at some point of time and then would start private practice. This fear was expressed by the PHC staff to a much greater extent than either by the District or the State level officials. Thus, while 73.8 per cent of the PHC staff agreed that "the CHWs will eventually become mini-doctors", whereas 41.6 per cent and 31.7 per cent respectively of the District and State level officials agreed to such a statement. Similarly, the percentages of those who agreed with the statement "the majority of the CHWs will start private practice", were 83.7, 48.6 and 43.3 for PHC staff, District and State level officials respectively. When several other negative statements were considered, the PHC staff were found to agree to a much greater extent than officials either at the District or the State levels. For instance, while 81.5 per cent of the PHC staff agreed with the statement "if the Government finds it difficult to meet the demand for medicines, this may ultimately harm the image of the PHC", these percentages for the District and State level officials were 47.9 and 56.7 respectively. Similarly, while 45.2 per cent of the PHC staff agreed with the statement "the Family Planning Programme is likely to suffer the most under the Scheme", only 4.9 per cent of the District level officials and 1.7 per cent of the State level officials felt that way. The PHC staff also agreed with the negative statement "the CHW Scheme will result in duplication of efforts between Multipurpose Workers and the CHWs" to a much greater extent (50.7%) than either the District (21.8%) or the State level officials (18.3%). These findings indicate that while the officials at the District and State levels appeared to be generally favourably inclined to the Scheme, the PHC staff were less favourably inclined specially when the negative statements were considered. The reasons for this

could be that they were more aware of the dangers and the pitfalls of the Scheme because they had been entrusted with the responsibility of implementation of the Scheme at the grass root levels. In all fairness, however, it needs to be pointed out that, in principle, the CHW Scheme was acceptable to the PHC staff as it was to the officials at the District and higher levels.

It may be said that, by and large, the community leaders, the Zila Parishad Presidents/Members, the BDOs and the officials at the PHC, District and State levels view the Scheme favourably when the theoretical assumptions of the Scheme are considered. The community leaders are tend to view the Scheme more favourably than Zila Parishad Presidents/Members either because their expectations from the Scheme are not very high or because their actual experience of the implementation of the Scheme, though limited, has been positive. An important finding is that the PHC staff are more sceptical about the various aspects of the Scheme than the officials at District and State levels, possibly because of their actual experience.

Acceptability in terms of wanting the CHW Scheme to continue

Two types of representatives of the people, that is, the formal and informal leaders at the community level and the Zila Parishad Presidents/Members, and two types of personnel of the Community Development Department, Block Development Officers (BDOs) and Village Level Workers (VLWs) were asked whether they would like the CHW Scheme to continue. Whether they replied in the affirmative or in the negative, they were further asked to give the reasons for their replies. The reasons for wanting the Scheme to continue are given in Appendix IX(a).

Almost all of them responded that they wanted the Scheme to continue (Community Leaders 96.7%, Zila Parishad Presidents/Members 85.7%, VLWs 98.0% and BDOs 94.5%). A variety of reasons were stated by them. The reasons for wanting the Scheme to continue given by the largest number of community leaders were -

- a. timely medical services/aid (38.0%);

b. treatment at doorstep (37.6%); and

c. helpful to poor people (28.5%).

According to the Zila Parishad Presidents/Members, the important reasons were that this Scheme was helpful to poor people (38.9%), and that it supplemented the health care system (36.1%). Timely medical services/aid was the reason given by the highest number of VLWs (45.0%). The other important reasons being 'treatment at doorstep' (41.7%) 'only agency of health education in villages' (29.4%), and 'helpful to poor people' (25.6%), while only 19 (3.1%) community leaders, three (7.1%) Zila Parishad Presidents/Members and three (1.5%) VLWs said that they did not want the Scheme to continue. It was worthwhile to find out why they felt that way. Unfortunately, information on this point was available for only four community leaders, all of whom reported that the CHW was irresponsible. This means that rather than commenting on the Scheme, in general, they had pinned down their reasons to the particular CHWs in their own villages. Two Zila Parishad Presidents/Members and VLWs were of the opinion that this Scheme would produce quacks in the village.

To sum up the CHW Scheme appears to be acceptable in principle to most of the respondents who were asked this question, and the most attractive feature of the Scheme being that it provided timely medical aid at the doorstep of the rural people.

Acceptability of the CHW to the community

Two types of workers were asked whether the CHW was acceptable to the community. The multipurpose/unipurpose workers (MPW/UPW) of the Health Department and the village level worker (VLW) of the Community Development Department were asked this question because they work very closely with the rural people and are usually quite sensitive to their reactions.

Almost all the MPWs/UPWs (94.8%) and VLWs (92.9%) reported that the CHW was acceptable to the community. This reply was of course, with reference to the particular CHW in question rather than to the CHW Scheme. The reason most often given by MPWs/UPWs was that the CHW provided health services

at doorstep (63.2%). The other reasons being: he/she is a resident of the village (40.7%) and he/she is a social worker (31.3%). The last two reasons were also the most important reasons mentioned by the VLWs, the percentages of such VLWs being 43.8 and 24.1 respectively.

Another indirect indicator of the acceptability of the Scheme to the community could be the extent to which they were prepared to take responsibility for the various aspects of the Scheme and thus get involved in the Scheme. Four aspects of the Scheme were taken up for study:

- i. payment of stipend during training;
- ii. payment of honorarium;
- iii. supplementing drugs and medicines; and
- iv. administrative control.

Community Leaders and VLWs were asked questions pertaining to these aspects related to their own villages and Zila Parishad Presidents/Members, BDOs were asked the same question with respect to the areas under their control.

It may be observed from Table 55 that the community leaders themselves did not think that the community would be interested in taking up any financial responsibility concerning this Scheme with respect to payment of stipends during training (65.7%), payment of honorarium (68.8%) and supplementing drugs (63.3%). The corresponding percentages for VLWs were 68.1, 67.5 and 56.9 respectively. It is obvious from these findings that the VLWs knew the people quite well with whom they have worked. When it came to 'administrative control', however, the majority of both the community leaders and the VLWs indicated that their communities would be quite willing to take up this responsibility (62.8% and 64.0%) respectively.

A more or less similar picture emerged when the responses of the Zila Parishad Presidents/Members and the BDOs were considered (Table 56). The majority of the Zila Parishad Presidents/Members and the BDOs said that 'none of the villages' would be willing to take up any financial responsi-

TABLE 55

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS AND VILLAGE LEVEL WORKERS ACCORDING TO THEIR VIEWS ABOUT THE RESPONSIBILITIES OF THE COMMUNITY WITH REGARD TO CHW SCHEME

Kind of Responsibility	Community leaders (N = 604)			Village level workers (N = 203)		
	No	Yes	Can't say	No	Yes	Can't say
Payment of stipend during training	65.7	21.6	12.7	68.1	12.7	19.3
Payment of honorarium	68.8	18.6	12.6	67.5	14.7	17.8
Supplementing drugs	63.3	23.8	12.9	56.9	30.0	13.2
Administrative control	28.8	62.8	8.3	24.9	64.0	11.2

bilities concerning the CHW Scheme. When it came to administrative control only 9.5 per cent of the Zila Parishad Presidents/Members and the 30.6 per cent of the BDOs said that 'none of the villages' would be willing to take up this responsibility, indicating that the majority felt either that 'most of the villages' or 'some of the villages' would be quite willing to do so.

When the CHWs were questioned whether their communities would be willing to contribute in case of shortage of medicines, 9.5 per cent replied in the negative. In only three cases, it was reported that the community had actually contributed for this purpose, one each from Maharashtra, Rajasthan and Sikkim.

Responses were elicited to another question pertaining to the extent of willingness of the community to bear financial responsibility of the Scheme concerning the expenses of training of a new CHW, if the old CHW left before the stipulated period. The findings are that 44.4 per cent of community

TABLE 56

PERCENTAGE DISTRIBUTION OF BDOs AND ZILA PARISHAD PRESIDENTS/
MEMBERS ACCORDING TO THEIR VIEWS ABOUT RESPONSIBILITIES
OF COMMUNITY WITH REGARD TO CHW SCHEME

Acceptance Scale	Payment of stipend		Payment of honorarium		Supplementing Drugs		Administra control	
	BDOs	ZPPs/Ms	BDOs	ZPPs/MS	BDOs	ZPPs/Ms	BDOs	ZPPs/Ms
	(N=73)	(N=42)	(N=42)	(N=42)				
Most of villages would accept	1.4	14.6	1.4	19.1	11.1	7.1	47.2	6
Some of villages would accept	30.6	29.3	20.8	19.1	31.9	35.7	22.2	2
None of the villages would accept	68.1	56.1	77.8	61.9	56.9	57.1	30.6	

leaders, 53.7 per cent of the Zila Parishad Presidents/Members and 36.5 per cent of the BDOs stated categorically that the community would never be willing to bear the expenses, while less than one per cent of the community leaders said that the community would be prepared to bear the expenses partially, either 50 per cent or 25 per cent. It is worth noting that 11.1 per cent of the BDOs stated that the Government should bear these expenses (Appendix IX(b)).

It is evident from these findings that the village communities appeared to have a tendency to depend heavily on the Government for financial assistance for all programmes and schemes which are launched for their benefit.

Satisfaction with the services provided by CHW

An important aspect of the acceptability of the Scheme is the extent to which community members are satisfied with the services provided by the CHW. Community members were asked two questions on this point:

- i. if they had ever received services provided by the CHW, if so, are they satisfied? and
- ii. if they never had any contact with the CHW but knew of someone else who had such an experience, are those relatives/friends satisfied with the services provided by the CHW?

A word of caution needs to be sounded in this regard. The period of experience available to the respondents with the work of CHW was very short, and, therefore, no firm conclusions can be drawn on the basis of these findings. Out of the 6,014 community members interviewed, this question was applicable to 3,600 (60.0%) respondents, indicating that they had some experience of the services provided by the CHW. Out of these, about 80 per cent reported that they were satisfied with the services. The most important reason for dissatisfaction with the services provided by the CHW, was the non-availability of medicines with the CHW. About 93 per cent of those who were dissatisfied cited this as the reason for their dissatisfaction. It is, thus, quite evident that the acceptability or otherwise of the CHW would depend quite heavily on the medicines which the CHW would be able to provide to the community members.

Out of those who themselves did not have any contact with the CHW, 1,080 knew someone who had received services from the CHW. It was found that 61.4 per cent of these 1,080 respondents reported that their relatives/friends who had received services provided by the CHW were satisfied with the services.

It may be concluded, however, that the findings related to the acceptability of the CHW Scheme to the community, is, by and large, acceptable to the community. An attempt was made to assess the acceptability of the Scheme on the basis of the willingness of the community to assume financial responsibility for the Scheme, and it was observed that no such willingness was forthcoming. The community was, on the other hand, ambitious to gain administrative control over the Scheme without assuming any financial responsibility.

The acceptability of the CHW Scheme would also depend to a great extent on the system of medicine followed by the CHW and also the preference of the community. It appears

that no dissatisfaction is likely to appear on this point. The CHWs were found to have been trained mainly in the modern system of medicine and a very high percentage of the community members interviewed were also found to prefer the same system, irrespective of whether it was for adult males (75.7%), adult females (75.4%) or for children (73.2%).

An important aspect of the CHW Scheme is the payment of honorarium, which is not meant to be considered as pay either by the CHW himself or the community. It is sometimes thought that this honorarium, though quite meagre in amount, yet is an incentive for the CHW to volunteer for this Scheme. Two questions were asked to the CHW:

- i. would you continue to work as CHW, if the honorarium was withdrawn?; and
- ii. do you think others would continue to work as CHW, if the honorarium was withdrawn?

The second question was intentionally asked because it was thought that the first question was too direct and, therefore, threatening to the ego of the CHW, and the replies may not be indicative of their true feelings.

It was found that more than three-fourths of the CHWs replied that they would be willing to continue to work as CHWs even if, the honorarium was withdrawn (Table 57). In

TABLE 57

PERCENTAGE DISTRIBUTION OF CHWs ACCORDING
TO THEIR WILLINGNESS TO CONTINUE TO WORK
EVEN IF HONORARIUM IS WITHDRAWN

Willingness	Males (N = 262*)	Females (N = 32*)	Total (N = 294)
Yes	75.6	87.5	76.9
No	22.5	9.4	21.1
Cannot say	1.9	3.1	2.0

*Responses were not available for five CHWs.

the sample of CHWs, there were only 33 female, out of whom information was not available from one respondent. On the basis of the available responses, it was found that female CHWs were willing to continue as CHWs without honorarium to a greater extent (87.5%) than male CHWs (75.6%).

The responses to this question were also cross-tabulated by age, educational status and the occupation of the CHWs and it was found that none of these characteristics made any difference to whether or not they were willing to continue as CHWs without honorarium.

To the indirect question on this point, however, the majority (57.2%) said that they could not say anything definite in the matter. The percentage of those who said either that others would not continue or would continue were 20.1 and 22.7 respectively.

It may, therefore, be concluded that at least from their own responses, it appears that more than three-fourths of the CHWs would be willing to continue to work even if, the honorarium was withdrawn.

Acceptability of the CHW Scheme to the PHC staff

The CHW Scheme is likely to be acceptable to the various categories of PHC staff if, either the CHWs are helpful to them in carrying out their own duties or if, they are not a hindrance in their work. The MPWs/UPWs who work directly with the CHWs were asked whether they thought the CHW was of any help to them in their work? The other staff of the PHCs, like the medical officers, the Block Extension Educators (BEEs) and the Sanitary Inspectors (SIs)/Health Inspectors (HIs) were asked what effect the CHW Scheme had on their normal work.

Out of the 225 MPWs/UPWs interviewed, information on this point was available for 171 as summarized in Table 58. Out of these 87.2 per cent reported that the CHW was helpful to him/her in his/her work. The main reason given by these who felt this way was 'the CHW helps to reduce my work' (56.1%) without giving any specific information as to what type of help was provided by the CHW.

As for the effect of CHW Scheme had on the normal work of

TABLE 58

PERCENTAGE DISTRIBUTION OF RESPONSES OF MPWs/
UPWs WITH RESPECT TO THE HELP CHW IS
ABLE TO PROVIDE IN HIS/HER WORK

Kind of Help	MPW/UPW (N = 171)
Assisting in rapport building	6.4
Helping in reducing my work	56.1
Assisting in house visits	7.6
Assisting in preparing list for immunization	33.3
Assisting in preparing blood slides for malaria cases	8.8
Assisting in the programme for controlling communicable diseases in the area	2.9
Assisting in Family Planning and Ante-natal and Post-natal work	19.9
Assisting in group meetings	1.8
Assisting in clinical work	2.3
Assisting in sanitation	5.9
Assisting in maintaining records of vital events	8.2
Assisting in referral services	4.1

Note: 1. Pertains to those MPWs/UPWs who said that they receive help from CHW.

2. The percentages do not total upto one hundred as more than one reason was mentioned.

various other categories of PHC staff, it was found that, by and large, the respondents stated that "there was no effect as such but in general the CHW was helpful".

It appears that the CHW Scheme was quite acceptable to the PHC staff as far as the assistance provided by the CHWs to them was concerned.

CHAPTER X

FEASIBILITY

The real test of feasibility of a Scheme, which ultimately intended to be a 'People's Scheme', is the willingness of the community to take over the Scheme in 'toto'. Thus, with reference to the Community Health Workers Scheme, an attempt has been made to analyse the feasibility in terms of:

- a. organizational adequacy;
- b. acceptability by the beneficiaries; and
- c. willingness of CHWs to continue, and the community to take over the Scheme after a certain period.

Organizational adequacy

In the guidelines issued by the Government of India, the objectives of the Scheme have not been defined in specific and measurable terms. Hence, they have been perceived differently by officers at State, District and Primary Health Centre levels. Similarly, there has been a variation in perception of roles of functionaries at PHC level and responsibilities of CHWs. The medical officers and supervisors at PHC level showed greater understanding of the objectives in terms of mix of curative, preventive and promotive roles of CHWs, as compared to officials at State and District levels.

Though the Scheme was launched on such a massive scale and was implemented quickly, yet the level of understanding of objectives of the Scheme, the roles and responsibilities of functionaries at PHC level and of CHW does not indicate much communication gap between policy makers at the Central level and implementators at the grass root level. This is also supported by the degree of awareness (76.7% of community leaders, 76.8% of CHWs and 63% of BDOs) of the Scheme before the selection of CHW, and the awareness of selection criteria of CHW amongst PHC and district staff.

The involvement of village community in selection of CHW as reported by CHWs (75.6%) and the criteria of selection having been adhered to a fairly high degree, are indicative of good organizational mechanisms built in between organized health services and community. Certainly, there are organizational inadequacies in certain areas; such as, non-availability of trained staff (38.5%) to undertake training of CHW, lack of physical facilities (reported by 49.1% of trainees), utilization of audio-visual aids and manuals probably on account of their non-availability (32.9% and 38.2% trainees of both batches, having not received the manuals at all or received after training respectively) and appointment of third medical officer at PHC (only 331 posts created in 412 PHCs out of a total of 741 PHCs where the Scheme was launched). The other inadequacies related to field training, untimely supply of medicines and delays in payment of honoraria. However, such initial problems are bound to be encountered in any massive programme of this nature. The improvement in supply of manuals for the second batch as compared to the first batch (Table 31) is an indication of strengthening the processes which may have taken place in other areas of inadequacies also.

It was noted that 90.7 per cent of CHWs spent two-three hours or more daily on health work and 60 per cent of community members contacted CHWs for one or more purposes. Apart from individual contacts, about 40-49 per cent of CHWs had conducted group meetings and distributed printed materials. Further, 52.9 per cent of CHWs had referred cases to MPW/UPW. On the other hand MPW/UPW had also contacted 73.6 per cent of CHWs during the previous one month. This is indicative of the degree of inter-face between staff of organized health services and Community Health Workers.

Acceptability by the beneficiaries

A very high percentage of respondents of different categories such as 94.1 per cent of formal and informal community leaders, 78.6 per cent of Zila Parishad Presidents/Members, 87.7 per cent of BDOs and 87.2 per cent, 86.6 per cent and 73.3 per cent of staff at PHC, District and State levels respectively expressed favourable attitude to the possible outcomes of the Scheme. Similarly, almost all respondents (community leaders 96.7%, Zila Parishad Presidents/Members 85.7%, VLWs 98.0% and BDOs 94.5%) wanted the Scheme to continue. Almost all the MPWs/UPWs (94.8%) and VLWs (92.9%)

45.7%, VLWs 98.0% and BDO's 94.5%) wanted the Scheme to continue. Almost all the MPWs/UPWs (94.8%) and VLWs (92.9%) reported that CHW was acceptable to the community.

Willingness of CHW to continue and the community to take over the Scheme

The willingness expressed by 76.9 per cent of CHWs to continue even if, honorarium was withdrawn, and the willingness of community (as reported by 62.8% of community leaders and 64.0% of VLWs) to have administrative control of CHW, are indicative of the extent of community participation in the programme. The discrepancy in terms of the community being willing to have administrative control but not to contribute substantially in terms of finances for purchase of medicines or other items or to assume full financial responsibility (as reported by about half to two-third of VLWs and community leaders) for the Scheme is nothing new and is too well known to anyone in the Indian setting.

Thus, the findings are an indication of the fact that the Scheme in its present form, with certain modifications to cover various inadequacies particularly the medicines, is likely to be acceptable to the other communities also, where it is likely to be extended. The findings on various dimensions of the study can be considered as indicators of the feasibility of the Scheme. Initial difficulties lay in the areas of administration and logistics. Once these are streamlined, the Scheme with certain modifications or suggested correctives as mentioned in Chapter XI 'Summary, Conclusions and Recommendations' will carry the promise of being successfully reproduced, if extended to other areas of the country. Thus, it can be stated that the Scheme is technically and administratively feasible and financially viable so long Government finances it.

CHAPTER XI

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The CHW Scheme was launched on 2nd October, 1977 as a part of the new health policy enunciated by the Government of India. It envisage to train a large number of persons as part-time semi-professional voluntary health worker, selected by the communities at the rate of one per 1000 population. Its aim was to provide simple medical aid besides preventive and promotive health services including family planning within the reach of every citizen. It was intended to cover 777 PHCs in all States and Union Territories (except those of Tamil Nadu, Kerala, Karnataka and Jammu & Kashmir) in the first phase. It was introduced in all the PHCs of 28 districts where the reorientation of unipurpose workers as multipurpose workers was completed and in one PHC selected from each of the remaining districts of the country. The total number of PHCs actually covered by the Scheme under the first phase, however, was 741. Despite considerable evidence available with regard to the successful functioning of such workers within the country (in experimental projects) and abroad, the Scheme had come for adverse criticism from a number of quarters. In order to facilitate its successful implementation, the need for systematic evaluation by independent agencies was recognized particularly in the context of its basic philosophy of community participation and their involvement in the Scheme.

Evaluation of the CHW Scheme

An independent evaluation of CHW Scheme was entrusted to the National Institute of Health and Family Welfare, New Delhi for carrying out the same on a national scale in collaboration with such other independent organizations who are willing to undertake the same. The evaluative study was initiated immediately in December, 1977. It was, however, recognized that a comprehensive evaluation of the Scheme, so early after its implementation, was fraught with a number of limitations particularly on the dimensions of performance and impact. The

dimensions to be covered for its evaluation, therefore, were carefully chosen. They were: (a) acceptability; (b) perception of objectives of the Scheme and roles and responsibilities of CHWs; (c) selection process; (d) training; (e) administration and logistics; and (f) performance.

Methodology

A representative sample of 76 PHCs was chosen for this purpose. A number of schedules were developed to cover up the relevant aspects of the each of dimensions included in this evaluative study. Interview method was the one used mostly for data collection. The respondents consisted of 60 State level officers, 142 district level officers, 142 medical officers and 227 supervisors at PHC level, 225 multipurpose/unipurpose health workers, 203 village level workers, 299 community health workers, 6,013 community members, 604 community leaders (both formal and informal), 73 BDOs and 42 Presidents/Members of Zila Parishads. The data thus collected was carefully analysed to depict the status of the Scheme in the country. Wherever appropriate, inter-State variations have been examined and presented. An attempt is made to summarize the same and draw meaningful conclusions and specific recommendations for the improvement of the Scheme.

Conclusions and Recommendations

a. Acceptability: There has been a massive support for this Scheme from almost all sections of the respondents. About 94 per cent of community leaders, 88 per cent of BDOs, 79 per cent of Zila Parishad Presidents/Members, reported that this Scheme would bring health care to the doorstep of the people. Further, 84.3 per cent of community leaders, 58.9 per cent of BDOs and 50 per cent of Zila Parishad Presidents/Members felt that it is an answer to the health problems in rural areas. Similar responses were obtained to a statement "neglected and poor sections of the villages will be looked after by the CHWs". Only 8.1 per cent of community leaders, 12.3 per cent of BDOs and 26.2 per cent of Zila Parishad Presidents/Members reported that the CHWs would take care of only the rich people in the villages. Further, 17.6 per cent of community leaders, 42.5 per cent of BDOs and 47.6 per cent of Zila Parishad Presidents/Members stated that politically powerful persons would use the CHW to make themselves

more influential. They have also stated, though to a small measure, that the CHW would become more interested in handing out medicine than in preventing diseases and promoting good health.

A large measure of positive response was obtained from PHC staff, district and State level officials. Also about 87 per cent of the PHC staff, 81 per cent of the district level officers and 73 per cent of the State level officers reported that the CHWs would enable early detection of certain diseases and prompt remedial actions. Such a large measure of positive response was also given to a statement 'scheme would make the health services responsive to the people's needs'. There were, however, certain statements which were indicative of negative reactions to it. About 83.7 per cent of the PHC staff, 48.6 per cent of the district level officers and 43.3 per cent of the State level officers opined that majority of CHWs would start private practice. Yet, 84.7 per cent of PHC staff, 28.9 per cent of district officers and 30 per cent of the State level officers disagreed that the CHW would over-emphasise curative functions.

Almost all respondents wanted the Scheme to continue, the reasons for continuation being that it provides timely medical services/aid at doorstep and could be helpful to the poor people. About 94 per cent of MPWs/UPWs and 92.9 per cent of VLWs reported that the Scheme was acceptable to the community.

However, 65.7 per cent of the community leaders and 68.1 per cent of village level workers reported that the community would not be interested in taking up any financial responsibility with respect to the payment of stipend during training. Similar responses were obtained with respect to the payment of honorarium. On the other hand, majority of both community leaders and VLWs indicated that their communities would be quite willing to take up the responsibility of administrative control of CHWs. Similar responses were obtained from Zila Parishad Presidents/Members and BDOs. The CHWs also similarly responded when asked whether their communities would be willing to contribute in case of shortage of medicines. In addition, more than three-fourth of the CHWs responded that they would be willing to continue to do work even if, the honorarium was withdrawn. Such responses was higher amongst female CHWs (87.5% than that amongst male CHWs (75.6%).

While considerable positive response was reported by majority, there exist certain apprehensions and fears such as CHWs shifting to curative medicine rather than preventive and promotive services; starting private practice; making money; improving their own political image; distributing medicine etc. The fears and apprehensions, though reported by a smaller section of the respondents, should be appreciated and necessary steps taken to nip the same in bud. In this connection, *it is recommended that continuous dialogues and discussions with officials at various levels should be initiated to dispel these fears and apprehensions*, in addition to a number of steps required to be taken which are recommended elsewhere in this Chapter.

b. Objectives, roles and responsibilities: The objectives, roles and responsibilities of personnel at various levels as per central guidelines and documents have not been clearly spelt out in this Scheme. Therefore, it was found that they were understood differently by officials at different levels of administrative set up. While 'health facilities at doorstep, treatment of minor ailments and health education' were considered to be the major objectives of this Scheme by the supervisors at PHC level, the MOs of PHC considered these objectives in a different order namely, 'health education, sanitation and preventive disease, treatment of minor ailments and health facilities at doorstep'. In the case of district and State level officials, 'treatment of minor ailments' happened to be the most frequently stated objective, followed by 'health facilities at doorstep'. 'Health education' was the third important objective in the case of district level officials, and 'link between community and PHC' in the case of State level officials.

The roles of MOs and supervisors at PHC level and those of multipurpose/unipurpose workers in the Scheme were obtained as perceived by the officials at various levels. 'Imparting of training, selection of appropriate candidates and sorting out difficulties of CHWs' were the three most important roles of medical officers as reported by State, district and PHC level staff. These officials viewed 'Imparting training, ensuring that field workers contact the CHW and work in harmony with them and supervising and evaluating the work of CHWs' are the three most important roles of supervisors at PHC level. They also viewed that the three most important roles of multipurpose/unipurpose health workers as 'keeping liaison with the CHW,

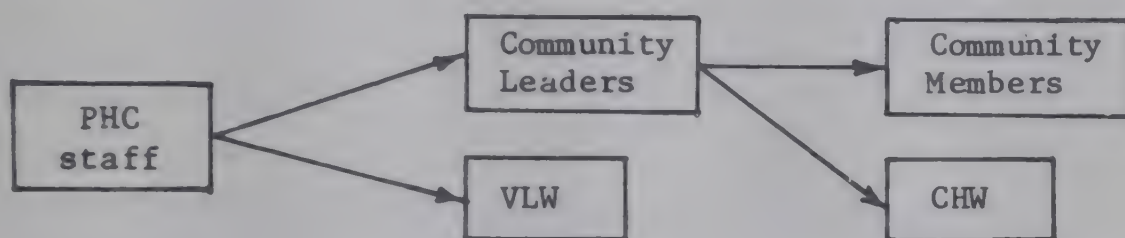
giving immunization to children and helping to build PHC image in the community'. The multipurpose/unipurpose health worker viewed their own roles as 'keeping liaison with the CHW, giving immunization to children and helping to build PHC image in the community'. In addition, they also visualized, 'rendering of help in maintaining records' as one of their roles.

All respondents, except BDOs and MOs, perceived 'treatment of minor ailments' as the most important responsibility of CHWs. BDOs and MOs, however, viewed 'providing of first-aid in emergencies and assisting health centre in immunization against smallpox and TB' as the most important responsibilities of CHWs. It is quite interesting to note that functions such as environmental sanitation, referral of deliveries, immunization, family planning work etc. were seldom seen to be the important responsibilities of the CHW, though the CHWs saw 'advice on small family norm' as the third most important responsibility of theirs.

These findings clearly show that there existed variation in the degree of understanding of objectives and roles to some extent and responsibilities to a greater extent between officials at different levels and CHW themselves. In this context, it is recommended that a systematic effort to reorient officials frequently at all levels, concerned with the implementation of the Scheme, should be organized. Further, various types of media available should be used to educate the people and the CHWs about the Scheme, its objectives and roles and responsibilities of different categories of functionaries in the Scheme.

The Scheme has certain operational objectives. The hierarchy of objectives for State, district and for the grass-root levels were however, absent. It is, therefore, recommended that specific objectives of the Scheme at different levels should be developed according to the local needs. In doing so, the community leaders who were supposed to be in administrative control of CHWs should be helped in developing the same, particularly with regard to the coverage of population with preventive and promotive care services and not minor ailments. This is all the more important because different categories of respondents viewed the roles and responsibilities of CHW as treatment of minor ailments.

c. Selection process: The responses obtained in different States showed that the selection process was satisfactory. Panchayat members and PHC staff were the main sources of information about the Scheme to CHWs. Further, 41.5 per cent of community leaders came to know about the Scheme through the PHC staff. In eight of the States, PHC staff was the major source of information. In Maharashtra and Uttar Pradesh, however, BDOs played a significant role of informants. Panchayats were the most dominant source of information to community members. The general pattern of sources of information about the Scheme to different categories of people is depicted in the diagram below:



It was found that almost all the selected CHWs approached some leader or the other for their selection. About 78 per cent of them approached Sarpanch/Village Pradhan. About 31 per cent of them approached more than one source, such as, Panchayat Members/Panchayat Secretary, MO (PHC), BDO etc.

The extent of involvement of community in the selection of CHWs was an important dimension of the Scheme. It was reported by 75.6 per cent of CHWs that community members were involved in their selection, whereas the rest stated that the community members were not involved. It is, however, possible that the word 'involvement' could have been interpreted differently by different interviewers and also understood differently by different CHWs. The response pattern clearly indicated that considerable involvement of community was obtained in the selection process of CHWs.

1. Scope of selection: The scope of selection in terms of number of candidates recommended for being considered for selection as a CHW was another crucial dimension. About 47 per cent of the CHWs responded that only one name was suggested. Further, 17.7 per cent stated that two names were suggested. In 8.4 per cent of the CHWs, as many as five or more names were suggested. However, recommending of single name was found to be the most common feature.

Community leaders (44.5%) when asked about the involvement of Gram Sabha of the village in the selection of CHWs stated that the Gram Sabha was involved in the process. On the other hand, 34.3 per cent of them stated that Gram Sabha was not involved. Considerable inter-State variations have been found in this regard. Further, extent of involvement of the PHCs and BDOs in the selection process also indicated substantial inter-State differentials.

While these findings clearly showed that there was considerable involvement of community leaders in the process of selection of CHWs, they also show that the same could further be strengthened. In this context, *it is recommended that necessary steps should be taken so that the selection of CHWs must be done by the community itself through the involvement of village Panchayats and Gram Sabhas.*

ii. Satisfaction: Majority (86.6%) of community leaders expressed satisfaction with the selection of CHW. Further, 94 per cent of them expressed satisfaction with the selected CHW for their village. It highlights high degree of satisfaction with regard to the selection process in general and the attitude of these leaders towards the selected CHW. It should be recorded that only one respondent stated that there was pressure from political leaders and four of them reported that there was pressure from influential persons in the selection of CHW.

iii. Selection criteria: The Scheme provided for considerable flexibility in the choice of CHWs. It, however, specified certain broad guidelines with respect to their residential status, educational qualifications etc. Such guidelines did not exist for other characteristics such as age, sex, occupation of the CHW.

It was found in the study that 13.4 per cent of the CHWs were below the age of 19 years. Only 6.3 per cent of them were females. It was also found that 23.2 per cent of the CHWs were 'never married' and 29.1 per cent of them had primary education. As many as 8.5 per cent of them had college or higher educational qualifications. While 70.2 per cent of the CHWs were reported to be engaged in agriculture, yet only 4.7 per cent of them were unemployed. Only 1.8 per cent of the CHWs were either *dais* or private practitioners. Nearly 21.2 per cent of

them were drawn from Scheduled Caste/Tribe communities. Substantial inter-State variations on these dimensions were found to exist. While the guidelines clearly spelt out that the selected CHW should be a resident of the same village, however, it was found that 97.9 per cent of the CHWs fulfil this criteria.

The findings suggest that certain general guidelines with respect to other socio-economic characteristics of CHWs would help in selecting those who are more suitable, more acceptable and whose credibility might not be questioned. It is premature to establish meaningful relationships between some of the socio-economic characteristics of CHWs and their performance so as to be able to specify the proper guidelines for the same. In the light of the available indirect and supportive information derived from the study, it is recommended that:

- i. local residents who enjoy the confidence of the community with willingness to undertake health work should be the most critical criteria that should be strictly adhered to;*
- ii. the CHW should preferably be above the age of 30 years;*
- iii. females should receive higher priority over males, wherever available;*
- iv. those who are unemployed or engaged in certain occupations such as shop-keeping should be discouraged and wherever possible ex-servicemen, dais etc. should get priority over others; and*
- v. while education upto 6th standard may remain as a minimum requirement, those with college or higher educational qualifications should be discouraged.*

d. Training: Training of CHWs is one of the most important inputs to their effective functioning. A number of aspects of this dimension such as pre-requisites for training, the training process in terms of its duration, content and methods used, the achievement of trainees need for refresher courses and the difficulties faced in undertaking the training, were examined.

It was found that as many as 38.5 per cent of trainers (MO, BEE, SI/LHV/HI) did not undergo the specified training so as to undertake inturn, the training of CHWs. The percentage was much higher in the case of MOs (55.3%) as compared to others.

1. Aids, methods, duration and contents: As many as 49.1 per cent of trainers reported that the physical facilities for undertaking the training of CHWs were inadequate. Audio-visual aids and manuals were occasionally used by 46.9 per cent of the trainers, whereas another 26.3 per cent never used them. The main reason for such low utilization of audio-visual aids was reported to be their non-availability. Further, only 2.1 per cent of CHWs reported that they received the manuals before training, whereas 38.2 per cent received after the training and another 32.9 per cent reported that they never received the manuals.

While indigenous systems of medicine were expected to be taught, qualified trainers in these subjects were hardly available. Further, 45.3 per cent of the posts of the third MOs filled so far were of Ayurveda system of medicine and only 14.2 per cent of them by those of Unani system of medicine. However, 40.5 per cent of them were filled by those belonging to modern system of medicine. Many of these posts were not even created in many of the States. On the other hand, there was high degree of preference on the part of community for modern system of medicine. Keeping in view of these considerations, teaching methods play an important role in the transfer of knowledge and skills. It was found that lecture method was used most frequently. Supervised field experience was only by 32.5 per cent of trainers. This method was particularly used in the teaching of environmental sanitation.

The duration of training vary from PHC to PHC. According to PHC staff, the average duration of training was found to be 9.9 weeks. The same according to CHWs was found to be of 7.2 weeks. It varied between eight to 12 weeks as per the records of the PHCs. Further, the duration of field training was also found to vary from State to State with average of 2.5 weeks. However, sizeable number (66.6%) of CHWs and 63.2 per cent of trainers felt that the duration of training was adequate.

As per the Scheme, the CHWs were to be trained in modern systems of medicine as well as in other systems of medicine

such as Homoeopathy, Sidha, Unani and Ayurveda. However, it was found that while Allopathic systems of medicine was covered in all training programmes, Ayurveda was included only in 64.3 per cent of the courses. Homoeopathy was covered in 28.8 per cent, Unani and Sidha in 30.6 and 26.7 per cent of courses respectively. Considerable inter-State variations in the coverage of different systems of medicine were observed. Rajasthan and Gujarat covered Ayurvedic systems of medicine to a larger extent than others.

ii. Achievement satisfaction and difficulties: For the purpose of assessing training achievement, a multiple choice test was administered. It was found that only 45.2 per cent of CHWs gave correct answers to items on 'measures for tackling certain diseases and physiological conditions'. Further, in relation to 'treating certain diseases and medical emergencies', a large percentage of them obtained one to three scores out of a maximum score of five. In areas such as malaria, immunization, nutrition and family planning, majority of them obtained two to three scores out of a maximum of five. Only 8.3 per cent of them received a score of one out of five. With regard to administration of certain specified medicines, the performance was found to be extremely poor in Homoeopathy, Ayurveda and Unani systems of medicine.

Though, 81.3 per cent of trainers reported that they were satisfied with the training imparted to CHWs, yet as much as 77.7 per cent of them emphasised the need for refresher courses.

A number of difficulties in undertaking the training of CHWs was reported by officials at State and district levels such as non-availability of third MO, non-payment of stipend during training, paucity of POL for field training, non-availability of manuals, lack of clarity in the instructions given by Government etc.

Thus, it could be seen that the training of CHW is one area where substantial improvements must be brought about. While perfection is utopian and relative, particularly in the context of its size, it should, however, be possible to maintain certain minimum standards. In this context, it is recommended that:

- i. *all the potential trainers should be trained adequately before implementation of the Scheme in a PHC;*

- ii. adequate literature such as books, manuals, teaching aids etc. should be made available to all the PHCs selected for implementation of the Scheme;
- iii. manuals should be supplied to all the trainers, as far as possible, during the very first week of their training so that the same could be studied and used extensively throughout the training programme by the trainees as well as the trainees;
- iv. supervised field training with emphasis on prevention and promotive aspects of health care should receive higher priority. Additional inputs such as POL should be made available for this purpose;
- v. it is further recommended that as far as possible the emphasis in the training programmes of CHWs should be on Allopathic systems of medicine. Other systems of medicine should be taught only when facilities for the teaching were available and where the community favoured their inclusion. This recommendation might go against the basic policy of the Scheme. It is, however, important that the findings available on the subject should be fully exploited in the development of training content so that it becomes relevant, need based and focused rather than diffused;
- vi. all the CHWs should be exposed to periodical refresher courses to reinforce their knowledge and skills;
- vii. mechanisms such as regular monthly meetings between PHC staff and CHWs should be initiated to discuss their difficulties and explore solutions together; and
- viii. training programmes currently being conducted should be systematically evaluated with a view to evolve appropriate teaching methods, optimum duration of initial training, content of refresher courses etc.

e. Administration and logistics: Successful implementation of the programme necessarily requires procurement and deployment of right type of resources at the right time and in right quantities. Three different kinds of resources, namely, medicines

one additional medical officer and honorarium were planned to be made available in the Scheme. They were examined with a view to identify the problems and difficulties in their supply.

1. Medicines: The CHWs were to be provided with a kit of medicines. However, it was found that 89.3 per cent of the trainees of the first batch (who completed their training by the end of December, 1977) received the kits either during or after the training. As many as 10.7 per cent of them did not receive them. Only 27.1 per cent of the second batch, who were undergoing training at the time of data collection for this evaluative study, received the kits.

While most of the States followed the list of medicines suggested by the Government of India without any change, some changes, however, were brought about in some States for reasons of prevalent disease pattern, availability of substitutes in local market and reducing the long list of items. However, it was found that only eight medicines out of the 20 were supplied and, that too, in 50 to 60 per cent of the PHCs. Ayurvedic and Homoeopathy medicines were received only by 16.2 per cent and 6.8 per cent of the PHCs, respectively. There were substantial inter-State variations in the supply of different types and number of medicines.

The CHWs were asked to indicate the medicines most used, not at all used, medicines demanded by community but not supplied and medicines in short supply. The responses to these questions were generally scanty possibly because of the fact that the CHWs were initiated into health work barely a couple of months ago.

Recognizing that there would exist gap between the demand and supply of medicines, the CHWs were asked whether their Panchayats would contribute to fill this gap. It was interesting to observe that 64.9 per cent of them stated that their village Panchayats would not contribute. On the other hand, about 15 per cent of them stated that they would contribute. Evidence of contribution was reported from the States of Maharashtra, Rajasthan and Orissa which certainly augurs well for the Scheme.

Medicines being an important input towards building rapport of the CHW with the community and establishing his credibility, shortfalls in the same might create problems in

the very acceptance of his services. *It is, therefore, recommended that the system of procurement and supply of medicines and drugs should be designed, based on methodologies of Material Management and adopted appropriately at different levels so that they reach the points of consumption at appropriate time in appropriate quantities.*

ii. Honorarium: The Scheme provides for payment of honorarium of Rs.50 per month per CHW. The interviews with the CHW, village leaders and BDOs revealed that considerable delays were occurring in its payment. Further, different agencies were entrusted with the responsibility of disbursement of honorarium in different States such as PHC, BDO etc. Though, the need for prompt payment of the same is unquestionable yet, the mode of payment and the agencies responsible for its payment deserve careful consideration. The Scheme having been based on community participation and panchayats having been vested with administrative control of CHWs, *it is recommended that entrusting the village panchayats with this responsibility in the long run should be considered.*

iii. Recruitment of third Medical Officer: It was found that the third MO was appointed only in a few States while in others even the creation of the same had not taken place. Wherever the posts were created, 80.3 per cent of them were filled up. Significant inter-State variations were found to exist on this dimension. While 95.8 per cent of the posts in Andhra Pradesh and 94.5 per cent in Uttar Pradesh were filled up, the same in Gujarat was 49.5 per cent. The background of the third MO was another important aspect which was discussed earlier. Keeping in view the differentials in the availability of MOs in different systems of medicine in different States, relatively much higher emphasis on allopathic system of medicine in the training of CHWs and predominant preference for allopathic system of medicine by community members, the decision with regard to the background of third MO needs to be reviewed. *In this context, it is recommended that third MO should preferably be appointed from those of modern system of medicine except in those PHCs where the circumstances favour MOs of other systems of medicine.*

f. Performance: The preliminary data collected on this dimension showed that about 59 per cent of CHWs were spending two to three hours a day on health work. As many as 68.5 per

cent of CHWs, community leaders, village level workers, BDOs and Zila Parishad Presidents/Members stated that the time spent by CHW on health work was adequate. It is to be recognized that it was too premature to make judgements on the performance of CHW at this stage, though the reported evidence on time spent, content of service and referrals elicited satisfaction of the community. A reasonable gestation period of at least two years is required for development of a good CHW. *It is recommended that during this period all necessary efforts, as indicated in terms of good supervision, periodical orientation and refresher courses etc. should be undertaken to strengthen his knowledge and skills, in addition to monitoring the Scheme for nipping in bud some of the evils that might come into being at some places as apprehended by some.*

g. Monitoring system: The Scheme did not visualize maintenance of any records whatsoever by CHWs. However, it was found in practice that a variety of records (a total of 13) were being maintained by a large number of CHWs. About 81 per cent of CHWs were maintaining a stock register for medicines. Other more commonly maintained records were for vital events, chlorination of wells and a daily diary. The basic question that arises, therefore, is whether or not to legitimize this activity.

The Scheme is based on the philosophy of community involvement and participation in the provision of primary health care services to the people. It implies that the community would eventually supplement the resources required for its continuation or would completely take it over at a subsequent point in time. However, the available evidence on this aspect presented elsewhere in this Chapter, does not speak much in support of the same. Therefore, Government will have to continue to finance it (recurring annual expenditure of about 600 million rupees on medicines and honorarium alone at current prices, after 1983) for a long time to come. If it is so, its effective functioning necessarily requires a monitoring system to provide continuous feedback on certain basic dimensions of the Scheme to bring about continuous improvements wherever called for. *It is, therefore, recommended that a simple monitoring system should be developed for concurrent evaluation of the Scheme. Further, the activity of maintaining records by CHWs should be legitimized. However, they should be rationalized and kept to a minimum within the framework of the information system for monitoring the Scheme.*

To conclude on the basis of the findings of the study, it is apparent that the Scheme was largely acceptable to the community. They were satisfied with the selected CHWs and the work being performed by him to a large measure. Further, the Scheme was found to be technically and administratively feasible. However, there existed a number of limitations in its implementation which need to be corrected. It should also be recognized that many of the apparent limitations were essentially attributable to the great speed with which it was implemented. The Scheme deserves periodical pause retrospection and review and gradual expansion phase by phase. In this context, it is recommended that the 741 PHCs where the Scheme is currently being implemented should be streamlined and completed before the same is expanded into other PHCs. During the intervening period, further expansion of the Scheme should be carefully planned and executed. As is apparent from the findings of the study on the dimensions of 'Training', it needs to be suitably linked with Multipurpose Workers Scheme where both should develop simultaneously because the Multipurpose Workers would be a commendable source of technical guidance and supervision to the CHW in the delivery of primary medical care services to the community.

APPENDICES

LIST OF FACULTY, RESEARCH AND SECRETARIAL STAFF
OF VARIOUS INSTITUTIONS/AGENCIES

1. NATIONAL INSTITUTE OF HEALTH AND FAMILY WELFARE,
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C. Editorial Staff

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C. Other Research Staff

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6. GANDHIGRAM INSTITUTE FOR RURAL HEALTH AND FAMILY PLANNING, TAMIL NADU

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2. Shri A. Muthiah
3. Shri T.S. Natarajan

APPENDIX II(a)

NUMBER OF PHCs AND PLCs SELECTED FOR THE STUDY - STATEWISE

State/Union Territory	No. of PFCs			No. of PHCs selected for the study		
	MPW	Non-MPW	Total	MPW	Non-MPW	Total
A. P.	84	17	101	8	2	10
Assam	--	10	10	-	1	1
Bihar	--	31	31	-	3	3
Gujarat	92	11	103	9	1	10
Haryana	16	9	25	2	1	3
H. P.	--	12	12	-	1	1
Madharashtra	77	20	97	8	2	10
M. P.	--	45	45	-	4	4
Manipur	8	5	13	1	1	2
Meghalaya	--	3	3	-	1	1
Orissa	--	13	13	-	1	1
Punjab	12	10	22	1	1	2
Rajasthan	--	27	27	-	3	3
Sikkim	--	4	4	-	1	1
Tripura	--	3	3	-	1	1
U. P.	134	48	182	13	5	18
W. Bengal	--	3	3	-	1	1
Nagaland*	--	7	7	-	1	1
Arunachal Pradesh*	--	5	5	-	1	1
Chandigarh	--	1	1	-	1	1
Goa, Daman & Diu	--	3	3	-	1	1
Mizoram	--	3	3	-	1	1
Pondicherry	--	3	3	-	1	1
	423	293	716	42	36*	78*

*On account of non-coverage of Arunachal Pradesh & Nagaland number of PHCs studied were 42, 34 and 76 for MPW, Non-MPW and total respectively.

APPENDIX-II(b)

**INSTITUTION-WISE ALLOCATION AND COVERAGE OF STATES/
UNION TERRITORIES FOR DATA COLLECTION**

Name of Institution	States/Union Territories covered
All India Institute of Hygiene and Public Health, Calcutta.	Assam Bihar Manipur Meghalaya Orissa Sikkim Tripura West Bengal Mizoram Arunachal Pradesh* Nagaland*
National Institute of Health and Family Welfare, New Delhi.	Haryana Himachal Pradesh Madhya Pradesh Punjab Rajasthan Uttar Pradesh (partly) Chandigarh
Gandhigram Institute of Rural Health and Family Planning, Tamil Nadu.	Pondicherry
International Institute for Population Studies	Andhra Pradesh Maharashtra Goa, Daman & Diu
Indian Institute of Management, Ahmedabad	Gujarat Uttar Pradesh (partly)

*Data not collected.

**THE ROLES OF MEDICAL OFFICERS, HEALTH SUPERVISORS AND
MULTIPURPOSE/UNIPURPOSE WORKERS**

Medical Officer

1. Imparting training.
2. Selection of proper candidates.
3. Projecting proper image of the CHW in his area.
4. Warning the villagers of the limited roles a CHW can play in curative practice.
5. Informing the community that CHW is not a government employee.
6. Informing the community of the correct nature of scheme.
7. Ensuring proper medicine used by the CHW.
8. Supervising the CHWs.
9. Treating the cases referred to by the CHW.
10. Improving the working of the sub-centres.

Health Supervisor

1. Imparting initial training.
2. Introducing the CHW in his new role.
3. Keeping liaison with the village leaders.
4. Ensuring that CHW has the necessary supply of medicines and equipments.
5. Supervising and evaluating CHW's work.
6. Ensuring that field workers contact the CHW and work in harmony.
7. Solving the difficulties of CHW.
8. Familiarising the community with the PHC.

Multipurpose/Unipurpose Health Worker

1. Keeping liaison with the CHW.
2. Giving immunization to children identified by CHW.
3. Preventing malpractice on the part of the CHW.
4. Supervising his work.
5. Finding out community's opinion about him.
6. Helping him to build PHC image in the community.

APPENDIX III(b)

LIST OF PERCEIVED RESPONSIBILITIES OF CHW AS DERIVED FROM THE DRAFT PLAN OF THE SCHEDULE AND MANUAL

1. Treatment of minor ailments.
2. Help to health staff in preventing communicable diseases.
3. Help in immunization work.
4. Refer pregnancy cases to dais.
5. Advise Pregnant mothers for TT immunization.
6. Advise mothers for D. P. T., Small Pox & B. C. G. immunisation to their children.
7. Help in personal hygiene.
8. Help people to keep their house clean.
9. Help people to keep village clean.
10. Educate people for nutritious diet.
11. First aid in emergencies.
12. Tell the benefits of small family.
13. Depot holder for family welfare works.
14. Advise people about the availability of the Family Welfare Services.
15. Refer for sterilization and MTP services.
16. Record vital events.
17. Educate people about the importance of registering vital events.

APPENDIX IV(a)

DISTRIBUTION OF COMMUNITY MEMBERS ACCORDING TO THEIR SOURCE OF
KNOWLEDGE ABOUT THE SCHEME - STATEWISE

State/Union Territory	State officials	District officials	PHC staff	BDO	Source of knowledge				N. A.	Total
					Panchayat	CHW	Villagers	Mass Media		
Andhra Pradesh	1	71	6	47	459	139	14	60	3	800
Bihar	2	55	12	57	16	34	5	40	19	240
Gujarat	1	125	5	63	242	202	28	126	9	801
Hararyana	0	30	0	26	55	39	2	87	3	242
Maharashtra	0	33	32	188	319	159	13	70	7	801
Madhya Pradesh	1	69	1	19	123	47	5	48	5	318
Rajasthan	1	35	6	6	65	38	0	102	0	243
Uttar Pradesh	2	117	60	340	239	295	80	295	8	1436
Himachal Pradesh,										
Punjab and	0	32	0	51	91	99	6	45	2	326
Chandigarh)									
West Bengal,)									
Assam, Tripura,)									
Mizoram,	2	52	1	93	202	86	8	112	4	560
Meghalaya and)									
Manipur)									
Orissa, Sikkim,)									
Goa, Daman &	3	24	0	58	44	52	9	54	2	246
Diu and)*									
Pondicherry										
Total	13	643	123	928	1855	1180	170	1039	62	6013

*Community members of Pondicherry are not included.

N. A: Number of community members who are not aware of the CFW Scheme.

APPENDIX IV(b)

PERCENTAGE DISTRIBUTION OF VLWs ACCORDING TO THEIR
SOURCE OF KNOWLEDGE ABOUT THE SCHEME - STATEWISE

State/Union Territory	N	State officials	Dist- rict offi- cials	PHC Staff	BDO	Pan- chayat	CHW	Villa- gers	Mass Media	NR	Total
Andhra Pradesh	31		3.2	48.4	12.9	9.7	9.7	3.2	9.7	3.2	100.0
Bihar	13			84.6	15.4						100.0
Gujarat	27			51.9	7.4	11.1	14.8		14.8		100.0
Haryana	4			25.0	50.0				25.0		100.0
Maharashtra	36			22.2	63.9	5.6			5.5	2.8	100.0
Madhya Pradesh	7			71.4			14.3	14.3			100.0
Rajasthan	11			27.3	27.2		9.1			36.4	100.0
Uttar Pradesh	40	2.5	5.0	17.5	37.5	2.5	2.5	5.0	25.0	2.5	100.0
Himachal- Pradesh, Punjab and Chandigarh	8		25.0	25.0	25.0	12.5			12.5		100.0
W. B., Assam, Tripura, Mizoram, Meghalaya and Manipur	19			26.3	21.1	10.5		15.8	10.5	15.8	100.0
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	77			28.6	28.6	14.3		14.3		14.2	100.0
Total	203	0.5	2.5	36.0	29.1	6.4	4.9	3.9	11.3	5.4	100.0

NR = Non responses

N = Total number of VLWs

APPENDIX IV(c)

DISTRIBUTION OF COMMUNITY LEADERS AND MEMBERS ACCORDING TO
THE KNOWLEDGE ABOUT THE NAME OF SELECTED CHW - STATEWISE

State/Union Territory	Could tell the name of the selected CHW	Total Number of responder
Andhra Pradesh	745	880
Bihar	216	264
Gujarat	738	881
Haryana	185	266
Maharashtra	790	881
Madhya Pradesh	302	350
Rajasthan	194	267
Uttar Pradesh	1399	1579
Himachal Pradesh, Punjab and Chandigarh	289	357
West Bengal, Assam, Tripura, Mizoram, Meghalaya and Manipur	498	616
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	220	276
Total	5576	6617

*Community members of Pondicherry are not included.

APPENDIX IV(d)

DISTRIBUTION OF COMMUNITY LEADERS ACCORDING TO
THE KNOWLEDGE ABOUT THE NUMBER OF PERSONS
NOMINATED FROM THE VILLAGE - STATEWISE

State/Union Territory	Number of persons nominated from the village						Do not know	Total
	1	2	3	4	5	6+		
Andhra Pradesh	43	9	3	5	2	1	17	80
Bihar	6	4	5	0	3	2	4	24
Gujarat	21	8	9	3	5	2	32	80
Haryana	4	2	3	0	2	10	3	24
Maharashtra	17	15	7	9	6	3	23	80
Madhya Pradesh	10	7	4	2	0	0	9	32
Rajasthan	9	3	2	2	0	2	6	24
Uttar Pradesh	53	13	22	5	7	15	28	143
H. P., Punjab Chandigarh	8	5	4	0	1	2	11	31
W. B., Assam, Tripura, Mizoram, Meghalaya and Manipur	15	7	15	2	3	2	12	56
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	7	4	3	0	1	4	11	30
Total	193	77	77	28	30	43	156	604

APPENDIX IV(e)

DISTRIBUTION OF COMMUNITY LEADERS ACCORDING TO
THEIR KNOWLEDGE ABOUT THE INVOLVEMENT OF
GRAM SABHA IN THE SELECTION - STATEWISE

State/Union Territory	No. of respon- dents having knowledge	Total No. of respondents
Andhra Pradesh	52	80
Bihar	7	24
Gujarat	31	80
Haryana	9	24
Maharashtra	40	80
Madhya Pradesh	6	32
Rajasthan	7	24
Uttar Pradesh	69	143
Himachal Pradesh, Punjab and Chandigarh	20	31
West Bengal, Assam, Tripura, Mizoram, Meghalaya and Manipur	19	56
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	9	30
Total	269	604

APPENDIX IV(i)

DISTRIBUTION OF RESPONSES OF BDOs ACCORDING TO THEIR INVOLVEMENT IN SELECTION OF CHWs - STATEWISE

State/Union Territory	Informing community about the scheme	Explaining about the selection in the meeting	Preparation of list of proposed names	Conducting panchayat meeting	Finalisation of names to be sent to MO and passing resolution	Conducting the interview	Final selection	Total
Andhra Pradesh	2	3	2	2	1	1	0	11
Bihar	2	1	1	1	1	1	2	9
Gujarat	5	3	1	2	1	1	4	17
Haryana	3	3	3	3	3	3	3	21
Maharashtra	7	5	4	5	6	3	4	34
Madhya Pradesh	3	2	2	0	0	3	3	13
Rajasthan	1	1	0	0	0	0	0	2
Uttar Pradesh	10	13	10	9	8	11	13	74
Himachal Pradesh,								
Punjab and Chandigarh	3	4	3	3	3	3	3	22
West Bengal, Assam, Tripura, Mizoram,								
Meghalaya and Manipur	4	2	2	2	1	2	1	14
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	2	2	1	2	1	1	1	10
Total	42	39	29	29	25	29	34	227

APPENDIX IV(g)

DISTRIBUTION OF RESPONSES OF ZILA PARISHAD PRESIDENTS ACCORDING
TO THEIR INVOLVEMENT IN SELECTION OF CHWs - STATEWISE

State/Union Territory	Informing the community about the scheme	Explaining about the scheme in the meeting	Preparation of list of proposed names	Conducting panchayat meeting	Finalization of names to be sent to MO and passing of a resolution	Conducting the interview	Final selection	Total
Andhra Pradesh	0	0	0	0	0	0	0	0
Bihar	0	0	0	1	0	0	0	1
Gujarat	3	3	1	2	2	0	1	12
Haryana	0	0	0	0	0	0	0	0
Maharashtra	5	4	1	2	1	1	1	15
Madhya Pradesh	1	0	0	0	0	0	0	1
Rajasthan	2	2	1	0	0	0	0	5
Uttar Pradesh	3	3	0	1	0	0	0	7
Himachal Pradesh, Punjab and Chandigarh	2	2	0	0	1	0	0	5
West Bengal, Assam, Tripura, Mizoram, Meghalaya and Manipur	2	2	2	2	2	1	2	13
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	0	1	1	1	1	0	1	5
Total	18	17	6	9	7	2	5	67

APPENDIX IV(h)

**DISTRIBUTION OF COMMUNITY LEADERS ACCORDING
TO THE DIFFICULTIES FACED IN THE SELECTION
OF CHWs - STATEWISE**

State/Union Territory	Difficulties faced in the selection of CHW			Total
	No	Yes	No response	
Andhra Pradesh	67	0	13	80
Bihar	22	0	2	24
Gujarat	62	2	16	80
Haryana	20	0	4	24
Maharashtra	65	1	14	80
Madhya Pradesh	26	0	6	32
Rajasthan	14	1	9	24
Uttar Pradesh	118	5	20	143
Himachal Pradesh, Punjab and Chandigarh	26	0	5	31
West Bengal, Assam, Tripura, Manipur, Mizoram, Meghalaya	47	2	7	56
Orissa, Sikkim, Goa, Daman and Diu and Pondicherry	17	2	11	30
All States	484	13	107	604

APPENDIX V(a)

PERCENTAGE DISTRIBUTION OF CHWs
BY AGE - STATEWISE

State/Union Territory	N	Age (Years)				All Ages	Average Age (Yrs.)
		15-19	20-29	30-39	40 +		
Andhra Pradesh	396	10.1	61.4	23.5	5.0	100.0	27.4
Bihar	189	5.8	64.0	24.9	5.3	100.0	28.0
Gujarat	389	14.9	66.8	18.3	0.0	100.0	25.7
Haryana	108	14.8	78.7	6.5	0.0	100.0	24.5
Maharashtra	330	2.1	59.1	33.0	5.8	100.0	29.2
Madhya Pradesh	147	4.8	78.9	15.6	0.7	100.0	26.3
Rajasthan	115	20.9	71.3	7.8	0.0	100.0	24.2
Uttar Pradesh	587	22.7	64.4	11.9	1.0	100.0	24.7
Himachal Pradesh, Punjab and Chandigarh	105	18.1	53.3	16.2	12.4	100.0	27.4
West Bengal, Assam, Tripura, Mizoram, Meghalaya and Manipur	162	18.5	68.5	11.1	1.9	100.0	25.0
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	76	3.9	92.1	3.9	0.0	100.0	25.1
All States	2604	13.4	65.9	17.9	2.8	100.0	26.3

N = Total number of CHWs (Both batches)
Av. = Average

APPENDIX V(b)

PERCENTAGE DISTRIBUTION OF CHWs BY SEX AND
MARITAL STATUS - STATEWISE

State/Union Territory	N	Sex		Marital Status			Unspeci- fied
		Male	Female	Never Married	Married	Widow/ Separa- ted	
Andhra Pradesh	396	94.7	5.3	36.6	62.6	0.8	0.0
Bihar	189	95.2	4.8	14.8	83.1	2.1	0.0
Gujarat	389	92.0	8.0	28.0	72.0	0.0	0.0
Haryana	108	99.1	0.9	32.4	67.6	0.0	0.0
Maharashtra	330	89.1	10.9	17.3	81.5	1.2	0.0
Madhya Pradesh	147	99.3	0.7	15.6	83.7	0.7	0.0
Rajasthan	115	100.0	0.0	16.5	48.7	0.0	34.8
Uttar Pradesh	587	99.3	0.7	8.5	87.9	0.1	3.4
Himachal Pradesh, Punjab and Chandigarh	105	86.7	13.3	26.7	70.5	2.8	0.0
West Bengal, Assam, Tripura, Mizoram, Meghalaya and Manipur	162	74.1	25.9	46.9	51.2	1.9	0.0
Orissa, Sikkim, Goa, Daman and Diu and Pondicherry	76	93.4	6.6	43.4	56.6	0.0	0.0
All States	2604	93.7	6.3	23.2	73.8	0.7	2.3

N = Total number of CHWs (Both batches)

APPENDIX V(c)

**PERCENTAGE DISTRIBUTION OF CHWs BY
EDUCATIONAL STATUS - STATEWISE**

State/Union Territory	Illiterate %	Primary %	High School %	College and above %
Andhra Pradesh	1.8	15.9	77.5	4.8
Bihar	0.0	27.0	47.1	25.9
Gujarat	0.0	34.2	63.0	2.8
Haryana	0.0	25.0	72.2	1.8
Maharashtra	0.0	30.0	69.4	0.6
Madhya Pradesh	0.0	14.3	78.9	6.8
Rajasthan	0.0	86.9	12.2	0.9
Uttar Pradesh	0.0	25.9	56.7	17.4
Himachal Pradesh, Punjab and Chandigarh	1.9	27.6	53.3	17.2
West Bengal, Assam, Tripura, Mizoram, Meghalaya and Manipur	0.0	27.8	69.1	3.1
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	0.0	50.0	48.7	1.3
All States	0.3	29.1	62.1	8.5

PERCENTAGE DISTRIBUTION OF CHWs BY OCCUPATIONAL PATTERNS - STATEWISE

State/Union Territory	N	Occupation							Unspecified %
		Agri-culture %	Shop Keeping %	House Keeping %	Landless Labour %	Dal's/Pvt. Practitioner %	Doing nothing %	Others %	
Andhra Pradesh	396	64.1	5.1	2.0	12.4	2.0	8.8	5.6	0.0
Bihar	189	77.3	6.4	4.2	7.9	2.6	0.0	1.6	0.0
Gujarat	389	61.9	10.3	5.7	7.9	1.3	1.5	13.6	0.0
Haryana	108	51.9	13.0	0.0	5.7	0.9	15.7	4.6	0.0
Maharashtra	330	61.2	2.7	4.9	14.5	0.6	0.0	4.2	11.8
Madhya Pradesh	147	76.2	1.4	0.7	8.1	0.7	4.1	8.8	0.0
Rajasthan	115	80.0	8.7	0.0	4.3	0.9	0.0	6.1	0.0
Uttar Pradesh	587	85.0	0.7	0.0	3.6	2.9	2.5	1.9	3.4
Himachal Pradesh, Punjab and Chandigarh	105	76.2	2.8	10.5	0.0	4.8	2.8	2.8	0.0
West Bengal, Assam, Tripura, Mizoram, Meghalaya and Manipur	162	51.9	2.5	8.0	3.1	1.2	22.8	10.5	0.0
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	76	80.3	2.6	1.3	1.3	0.0	5.3	9.2	0.0
All States	2604	70.2	4.6	3.1	7.4	1.8	4.7	5.9	2.3

N = Total number of CHWs (both batches)

APPENDIX V(e)

PERCENTAGE DISTRIBUTION OF CHWs BY CASTE AND PLACE OF RESIDENCE - STATEWISE

State/Union Territory	N	Caste SC/ST %	Non-SC/ST %	Unspecified			Place and Residence	
				%	Within village %	Outside village %	Unspecified %	
Andhra Pradesh	396	34.6	65.4	0.0	99.4	0.6	0.0	
Bihar	189	12.2	87.8	0.0	100.0	0.0	0.0	
Gujarat	389	19.5	80.5	0.0	89.5	0.2	10.3	
Haryana	108	23.0	76.9	0.0	95.4	4.6	0.0	
Maharashtra	330	9.1	80.0	10.9	98.8	1.2	0.0	
Madhya Pradesh	147	20.4	79.6	0.0	100.0	0.0	0.0	
Rajasthan	115	20.9	79.1	0.0	100.0	0.0	0.0	
Uttar Pradesh	587	15.0	85.0	0.0	100.0	0.0	0.0	
Himachal Pradesh, Punjab and Chandigarh	105	20.0	80.0	0.0	100.0	0.0	0.0	
West Bengal, Assam, Tripura, Mizoram, Meghalaya and Manipur	162	51.9	48.1	0.0	98.1	1.9	0.0	
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	76	19.7	80.3	0.0	100.0	0.0	0.0	
All States	2604	21.2	77.4	1.4	97.9	0.6	1.5	

N = Total number of CHWs (Both batches)

APPENDIX VI(a)

SAMPLE OF QUESTIONS FOR MEASUREMENT OF KNOWLEDGE OF CHW

1. Please mention name and dosage of medicine (under the system being practised by the CHW) for the patient suffering from the following symptoms:
 - a. A three year old child suffering from Malaria.
 - b. A twenty year old young man suffering from Vomiting.
 - c. A forty year old man having fever and headache.
 - d. A six months old baby having loose motions.
 - e. Pain in abdomen of a thirty year old full term pregnant woman.
2. When should you refer patient suffering from the loose motions to more qualified government health officials:
 - i) Stool contains blood and mucus.
 - ii) Diarrhoea is accompanied by fever and vomiting.
 - iii) Stool looks like rice water.
3. What services need to provide in the village to reduce deaths in children below one year:
 - i) Immunization.
 - ii) Early and prompt treatment if, child is ill.
 - iii) Good nutrition.
 - iv) Proper personal hygiene in preparation of food for the child.
4. How will you deal with the following emergencies ?

Drowning: i) Encourage the water to run out of the lungs.

ii) Apply artificial respiration.

iii) Don't let the patient sit up and send him on a stretcher to PHC for treatment.
5. What are you expected to do in relation to following conditions ?

Malaria: i) Identify fever cases.

ii) Make blood slides of all fever cases and give names to health worker.

iii) Administer presumptive treatment to fever cases.

iv) Educate the community as how to prevent Malaria.

v) Assist in spray operations.

APPENDIX VI(b)

PERCENTAGE DISTRIBUTION OF THIRD MEDICAL OFFICER, COMMUNITY REFERENCE FOR
THE SYSTEMS OF MEDICINE AND THE SYSTEMS OF MEDICINE ADEQUATELY
COVERED IN THE TRAINING OF CHWs

State/Union Territory	Recruitment of 3rd M.O.				Community preference (percentage)					System of medicines covered adequately (percentage)				
	MBBS	A U Total			Ally.	A H U S				Ally.	A H U S			
		A	U	Total		A	H	U	S		A	H	U	S
Andhra Pradesh	94	-	-	94	98.47	1.49	0.04	-	-	70.8	11.7	5.9	5.9	5.9
Bihar	-	-	-	-	88.3	1.1	10.6	-	-	100.0	-	-	-	-
Gujarat	28	23	-	51	85.2	14.4	0.4	-	-	86.7	33.3	-	-	-
Haryana	-	-	-	-	93.2	5.4	1.4	-	-	50.0	25.0	25.0	-	-
Maharashtra	-	-	-	-	88.9	7.1	0.6	3.4	-	100.0	-	-	-	-
Madhya Pradesh	-	-	-	-	87.8	5.2	6.7	-	0.3	83.3	16.7	-	-	-
Rajasthan	-	-	-	-	88.8	11.0	-	0.2	-	25.0	50.0	25.0	-	-
Uttar Pradesh	-	127	47	174	82.5	10.5	5.4	0.3	1.3	53.8	35.9	2.6	7.7	-
Himachal Pradesh, Punjab and Chandigarh	-	-	-	-	93.4	4.9	1.7	-	-	100.0	-	-	-	-
West Bengal, Assam, Tripura, Mizoram, Meghalaya and Manipur	9	-	-	9	93.4	0.4	5.8	0.2	0.2	100.0	-	-	-	-
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	3	-	-	3	92.9	2.4	4.7	-	-	100.0	-	-	-	-

Ally. = Allopathy, A = Ayurvedic, H = Homoeopathy, U = Unani and S = Sidha

PERCENTAGE DISTRIBUTION OF CHWs REGARDING MEDICINES
USED MOST, MEDICINES NOT USED AT ALL ETC.

Medicines	Medi- cines used most	Medi- cines not at all used	Medicines demanded by com- munity but not supplied	Medi- cines in short supply
1. Novalgin	1.6	-	0.7	1.6
2. Paracetamol	30.6	2.0	3.6	13.2
3. Magnesium Hydroxide	18.1	3.3	1.3	4.3
4. Cough Mixture/Syrup	32.9	3.3	4.3	17.8
5. Chloroquin/Comoquinine	24.0	0.7	4.9	6.2
6. Sulphacetamida tab.	1.6	-	1.0	0.7
7. Sulphadimidin	6.2	0.3	2.0	3.9
8. Eye drops	13.8	2.0	1.6	3.6
9. Dressing Material	4.3	0.7	4.3	2.0
10. Piperazine tab. /syrup	7.2	9.9	1.0	2.3
11. Multivitamin	2.3	0.3	2.6	0.3
12. Sulphaguamidine	4.3	1.3	2.3	5.9
13. A. P. C.	24.0	1.0	9.9	13.5
14. Murcuro Chrome/G. V. Paint	12.5	1.3	2.0	1.3
15. Balladona Plaster	-	0.3	-	-
16. Metacin Syrup	7.7	-	1.0	3.3
17. Siquil	0.3	-	2.3	-
18. Ear Drops	2.6	0.3	2.3	1.0
19. Eye Ointment	6.9	1.3	1.3	2.3
20. Plaster of Paris for fracture	0.3	-	0.3	-
21. Injections	-	-	1.0	1.0
22. Benzyle Benzoate	28.3	3.0	5.9	6.9
23. Kaolin Powder	13.2	3.3	1.0	2.3
24. Influenza Tablets	1.3	-	-	1.0
25. Iron & Folic Acid	1.6	-	1.0	0.7
26. Avomine	0.7	-	0.7	0.3
27. Avil	-	-	0.3	-
28. Antiseptic lotion	0.3	0.3	1.3	0.7
29. Baralgan	-	-	0.7	-
30. Tetracycline Tab. /Syrup	0.7	-	1.0	-
31. Subamycin Vitamin B. Complex	-	-	2.0	-

Contd...

1	2	3	4	5
32. Pottasium Permangnate	1.0	0.7	-	1.0
33. Calcium	-	-	0.3	-
34. Digene	0.3	-	0.3	-
35. Tr. Benzyomi Co.	0.3	-	-	-
36. Furacin Oint. (Skin)	1.0	-	0.3	0.3
37. Carminative Mixture	0.3	-	-	0.3
38. Burnol	0.3	-	-	-
39. Bellargal	-	-	-	-
40. Enteroquinol	-	-	0.3	-
41. Bleaching Powder	-	-	0.3	-
42. Eurax	-	-	0.3	-
43. Boric Powder	1.3	-	-	-
44. Soda Mint	7.2	-	0.7	-
Medicines not supplied	18.1	18.1	18.1	18.1

Total respondents = 299

Note: Four CHWs of Manipur are excluded, as they were under training at the time of study.

APPENDIX VII(b)

PERCENTAGE DISTRIBUTION OF CHWs FOR RESPONSES
OF WILLINGNESS OF PANCHAYATS TO CONTRIBUTE
TO GET MORE MEDICINES

State/Union Territory	Panchayat would contribute in case of shortage of medicines	Panchayat actually contributed in case of shortage of medicines during last two months
Andhra Pradesh	10.0	-
Bihar	8.3	-
Gujarat	22.5	-
Haryana	41.7	-
Maharashtra	20.0	2.5
Madhya Pradesh	25.0	-
Rajasthan	41.7	8.3
Uttar Pradesh	7.5	-
Himachal Pradesh, Punjab and Chandigarh	6.2	-
Assam, Mizoram, Meghalaya, Manipur, Tripura and West Bengal	4.2	-
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	10.0	5.0
Total	15.0	1.0

APPENDIX VII(c)

PERCENTAGE DISTRIBUTION OF CHWs
MAINTAINING RECORD - STATEWISE

State/Union Territory	CHWs maintaining records		Total No. of CHWs
	No.	Per cent	
Andhra Pradesh	39	97.5	40
Bihar	6	50.0	12
Gujarat	40	100.0	40
Haryana	12	100.0	12
Maharashtra	22	55.0	40
Madhya Pradesh	15	93.8	16
Rajasthan	7	58.3	12
Uttar Pradesh	67	94.4	71
Himachal Pradesh, Punjab and Chandigarh	16	100.0	16
Assam, Manipur, Meghalaya, Tripura, West Bengal and Mizoram	20	83.3	24
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	15	93.8	16
All States	259	86.6	299

APPENDIX VII(d)

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS, BDOs AND ZILA
PARISHAD PRESIDENTS/MEMBERS ACCORDING TO THEIR OPINION
WHETHER HONORARIUM IS SUFFICIENT AND IF, NOT SUFFICIENT
WHAT SHOULD BE THE HONORARIUM - STATEWISE

State/Union Territory	Hono- rarium suffi- cient	Amount of honorarium suggested in case it is not sufficient						Total
		75	100	125	150	175 or more	Amount not specified	
Andhra Pradesh	5.5	3.6	27.4	1.2	8.3	4.8	54.7	100.0
Bihar	21.4		5.0	-	-	5.0	90.0	100.0
Gujarat	37.9	3.6	32.7	7.3	12.7	3.6	40.1	100.0
Haryana	21.4	-	13.7	-	31.8	40.9	13.6	100.0
Maharashtra	30.9	4.5	28.4	3.0	7.5	7.3	49.3	100.0
Madhya Pradesh	20.5	3.7	48.1	-	11.2	3.7	33.3	100.0
Rajasthan	17.2	9.1	22.7	-	31.8	22.8	13.6	100.0
Uttar Pradesh	17.4	3.7	23.5	1.5	13.2	8.1	50.0	100.0
Himachal Pradesh, Punjab and Chandigarh	52.6	-	23.5	-	5.9	-	70.6	100.0
Assam, Manipur, Meghalaya, Tripura, Mizoram and West Bengal	22.7	-	8.2	-	10.2	16.4	65.2	100.0
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	13.9	3.3	23.4	-	6.7	3.3	63.3	100.0
All States	23.1	3.2	24.4	1.7	11.7	8.9	50.1	100.0

**RESPONSES TO STATE OFFICIALS (OFFICER-IN-CHARGE CHW
SCHEME) REGARDING FILLING UP OF THE THIRD MEDICAL
OFFICER'S POSTS UNDER DIFFERENT SYSTEM OF
MEDICINE IN CHW's BLOCKS - STATEWISE**

State/Union Territory	Number of posts			No. of 3rd Medical Officer appointed to			Remarks
	Crea- ted	Filled	Per cent	Allopa- thic	Ayur- vedic	Unani	
Andhra Pradesh	98	94	95.8	94	-	-	
Bihar	-	-	-	-	-	-	Post not created or filled
Gujarat	103	51	49.5	28	23	-	
Haryana	-	-	-	-	-	-	-do-
Maharashtra	-	-	-	-	-	-	-do-
Madhya Pradesh	-	-	-	-	-	-	-do-
Rajasthan	-	-	-	-	-	-	Data not collected
Uttar Pradesh	184	174	94.5	-	127	47	
Himachal Pradesh, Punjab and Chandigarh	-	-	-	-	-	-	Post not created or filled
Assam, Manipur, Meghalaya, West Bengal, Tripura and Mizoram	22	9	40.9	9	-	-	
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	5	3	60.0	3	-	-	
All States	412	331	80.3	134	150	47	

Note: In Homoeopathy or Sidha no post has been created so far in any State in India.

APPENDIX VII(f)

**PERCENTAGE RESPONSES OF DIFFERENT STATE OFFICIALS
REGARDING FILLING UP OF THE POST OF THIRD
MEDICAL OFFICER - STATEWISE**

State/Union Territory	Responses of						Total per cent filled
	Direction for creation of posts		Programme Officer-in-Charge CHW		Other Officers		
	Created	Filled (Per cent)	Created	Filled (Per cent)	Created	Filled (Per cent)	
Andhra Pradesh	98	100.0	98	95.9	98	100.0	98.6
Bihar	-	-	-	-	587	91.5	91.5
Gujarat	126	80.2	103	49.5	-	-	66.4
Haryana	-	-	-	-	-	--	-
Maharashtra	-	-	-	-	-	-	-
Madhya Pradesh	-	-	-	-	-	--	-
Rajasthan	-	-	-	-	-	-	-
Uttar Pradesh	(No. not mentioned)		184	94.6	-	-	94.6
Himachal Pradesh, Punjab and Chandigarh	-	-	-	-	-	-	-
Assam, Manipur, Meghalaya, West Bengal, Tripura and Mizoram	9	100.0	11	9.1	3	100.0	56.5
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	3	100.0	3	33.3	5	40.0	54.5
All States	236	94.1	399	80.5	693	92.4	88.0

Note: In Homoeopathy and Sidha no post has been created so far in any States in India.

APPENDIX VIII(a)

PERCENTAGE DISTRIBUTION OF THE RESPONSES OF CHWs ACCORDING TO THE
TIME OF AVAILABILITY OF THEIR SERVICES TO COMMUNITY - STATEWISE

State/Union Territory	N	Morning	Noon	After-noon/ Evening	No fixed time	Morn- ing and Evening	Non-response	Total
Andhra Pradesh	40	75.0	-	5.0	12.5	5.0	2.5	100.0
Bihar	12	-	-	-	41.7	58.3	-	100.0
Gujarat	40	35.0	10.0	15.0	5.0	32.5	2.5	100.0
Haryana	12	50.0	-	25.0	25.0	-	-	100.0
Maharashtra	40	45.0	7.5	7.5	15.0	7.5	17.5	100.0
Madhya Pradesh	16	31.3	6.2	6.2	37.5	18.8	-	100.0
Rajasthan	12	25.0	-	16.7	50.0	-	8.3	100.0
Uttar Pradesh	71	42.3	8.5	5.6	5.6	36.6	1.4	100.0
Himachal Pradesh,								
Punjab and								
Chandigarh	16	25.0	6.2	31.3	37.5	-	-	100.0
West Bengal, Assam,								
Tripura, Mizoram,								
Meghalaya and								
Manipur	24	25.0	-	16.7	29.1	25.0	4.2	100.0
Orissa, Sikkim, Goa,								
Daman & Diu and								
Pondicherry	16	18.8	6.2	6.3	12.5	56.2	-	100.0
All States	299	39.8	5.3	10.4	17.4	28.1	4.0	100.0

N = Total number of CHWs

APPENDIX VIII(b)

PERCENTAGE DISTRIBUTION OF THE RESPONSES OF DIFFERENT
LEVEL OF OFFICIALS REGARDING ADEQUACY OF TIME SPENT
BY CHWs ON THEIR ACTIVITIES - STATEWISE

State/Union Territory	CHW and other official reporting adequacy of time				
	CHW (N = 299)	Community Leader (N = 604)	VLW (N = 203)	BDO (N = 73)	Zila Parishad Presidents/ Members (N = 42)
Andhra Pradesh	67.5	58.7	51.6	50.0	-
Bihar	66.7	60.9	76.9	100.0	50.0
Gujarat	90.0	75.0	70.4	70.0	83.3
Haryana	75.0	91.7	75.0	66.7	100.0
Maharashtra	50.0	77.5	44.4	50.0	57.1
Madhya Pradesh	68.7	90.5	42.9	100.0	75.0
Rajasthan	66.7	70.8	45.4	100.0	100.0
Uttar Pradesh	77.5	78.3	70.0	55.6	72.7
Himachal Pradesh, Punjab and Chandigarh	87.5	80.7	87.5	75.0	100.0
West Bengal, Tripura, Meghalaya and Manipur	50.0	63.1	29.4	33.6	50.0
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	50.0	50.0	55.5	66.7	
All States	68.9	72.7	57.6	61.7	69.0

APPENDIX VIII(c)

PERCENTAGE DISTRIBUTION OF THE RESPONSES OF THE COMMUNITY MEMBERS ACCORDING TO THE PURPOSES FOR WHICH THEY CONTACTED CHW - STATEWISE

Disease	Andhra Pradesh N = 2400	Bihar 720	Gujarat 2403	Haryana 726	Maharashtra 2403	Madhya Pradesh 954	Rajasthan 729	Uttar Pradesh 4308	Himachal Pradesh 978	West Bengal 1473	Orissa etc. 948	Total 18042
Disease not specified	7.3	30.7	15.2	23.8	10.1	14.1	21.8	9.1	14.3	15.9	20.0	13.5
Fever	12.8	2.2	7.7	5.2	4.1	7.1	5.5	6.8	7.0	5.3	3.9	6.8
Cough/Cold	5.7	1.7	1.5	3.0	1.7	2.1	0.9	3.7	5.5	3.3	1.2	3.1
Dysentery	0.6		0.5	0.1	0.1	0.9	0.3	0.6	0.1	1.2	0.1	0.5
Loose Motions	1.9	0.3	0.4	0.1		1.9	0.1	0.2	0.1	0.9	0.8	0.6
Headache	2.9		1.6	1.1	0.5	1.5	0.5	1.3	2.1	1.3	0.7	1.3
Stomach pain	1.8		0.7	0.4	0.0	0.5		1.7	0.7	0.8	0.2	0.9
Eye Trouble	0.5	0.3	0.9	0.1	0.0	0.6	0.1	0.4	0.2	0.0	0.1	0.4
Injury	0.2		1.0	0.0	0.1	0.7	0.1	0.6		0.5	0.4	0.4
Immunization/Vaccination	0.7	3.6	0.1	0.0	1.4	0.3		0.1		0.6	0.3	0.5
Skin diseases	1.3		0.5	0.4	0.0	0.1	0.8	2.6	0.1	1.3	0.2	1.0
Malaria	0.3		0.7	1.8	0.3	2.7	0.4	0.8	0.2	0.6	0.3	0.7
Other ailments	3.4	3.3	2.1	1.1	1.2	3.4	2.6	2.7	0.9	2.8	1.1	2.4
N. A.	60.6	57.9	67.1	62.2	80.6	64.0	68.7	69.3	68.8	65.4	70.7	67.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Community members of Pondicherry are not included.
N. A.: Number of community members who did not contact their respective CHWs.
N = Number of respondents adding the responses for three purposes.

APPENDIX VIII(d)

PERCENTAGE DISTRIBUTION OF THE RESPONSES OF THE CHWs
ACCORDING TO DIFFERENT ACTIVITIES UNDERTAKEN AND
ACTIVITIES FOR WHICH ASSISTANCE RENDERED MOSTLY
OR SOME TIMES DURING THE LAST 2 MONTHS - STATEWISE

State/Union Territory	N	Activities undertaken			Activities for which assistance rendered			
		Indi- vidual con- tacts	Group Meet- ings	Distri- bution of Printed Mate- rial	Mass Meet- ings	Film shows	Exhi- bitons	Service camps
Andhra Pradesh	40	97.5	60.0	35.0	57.5	35.0	15.0	27.5
Bihar	12	91.7	97.0	41.7	75.0	8.3	8.3	-
Gujarat	40	100.0	50.0	47.5	37.5	40.0	12.5	27.5
Haryana	12	100.0	75.0	58.3	33.3	16.6	-	16.7
Maharashtra	40	72.5	12.5	42.5	27.5	2.5	5.0	20.0
Madhya Pradesh	16	100.0	50.0	43.8	37.5	6.2	-	6.2
Rajasthan	12	75.0	58.4	41.7	50.0	25.0	16.7	16.7
Uttar Pradesh	71	97.2	33.8	33.8	49.3	9.9	11.3	9.9
Himachal Pradesh, Punjab and Chandigarh	16	93.8	56.2	6.2	18.7	12.5	-	43.8
West Bengal, Assam Assam, Tripura, Meghalaya and Manipur	24	100.0	70.8	41.7	41.7	16.7	8.3	8.3
Orissa, Sikkim, Goa, Daman & Diu and Pondicherry	16	100.0	62.5	68.6	68.8	25.0	6.3	43.8
All States	299	93.7	48.2	40.2	44.5	18.4	9.0	19.4

N = Total number of CHWs

APPENDIX VIII(e)

PERCENTAGE DISTRIBUTION OF THE RESPONSES OF COMMUNITY
MEMBERS ACCORDING TO THEIR SATISFACTION TOWARDS
SERVICES PROVIDED BY THE CHW - STATEWISE

State/Union Territory	N	Satisfaction from services provided by the CHW			Total
		No	Yes	N.A.	
Andhra Pradesh	800	8.7	63.9	27.4	100.0
Bihar	240	15.0	69.6	15.4	100.0
Gujarat	801	15.6	48.6	35.8	100.0
Haryana	242	24.8	32.6	42.6	100.0
Maharashtra	801	8.7	30.5	60.8	100.0
Madhya Pradesh	318	13.5	54.7	31.8	100.0
Rajasthan	243	21.4	30.0	48.6	100.0
Uttar Pradesh	1436	8.1	53.0	38.9	100.0
Himachal Pradesh, Punjab and Chandigarh	326	12.9	43.9	43.2	100.0
West Bengal, Assam, Tripura, Mizoram, Meghalaya and Manipur	490	12.4	49.9	37.7	100.0
Orissa, Sikkim, Goa, Daman & Diu* and Pondicherry	316	18.7	28.2	53.1	100.0
All States	6013	12.2	47.8	40.0	100.0

* Community members of Pondicherry are not included.

N = Total number of community members.

N. A. = Number of community members who did not contact the CHW for any health matter during the last one month.

**PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS, ZILA
PARISHAD PRESIDENTS, VLWs AND BDOs ACCORDING TO THE
REASONS FOR WANTING THE SCHEME TO CONTINUE**

Reasons	Community Leaders N=582 NR = 22	Zila Parishad President/ Member N = 36 NR = 6	VLWs N = 180 NR = 23	BDOs N = 69 NR = 4
Too early to comment	7.6	8.3	-	2.9
Helpful to poor people	28.5	38.9	25.6	20.3
Treatment at door-step	37.6	13.9	41.7	15.9
Timely medical services aid	37.9	13.9	45.0	29.0
Only agency of health education in village	11.2	2.8	29.4	10.1
Will create awareness of nutritious diets	-	-	1.1	1.4
Will create awareness of F.W.	3.6	-	2.8	1.4
Relief to community during epidemic	2.9	-	5.6	2.9
Free supply of medicine to village	-	-	1.7	-
Time and money of the villagers will be saved	-	-	8.9	-
For better prospects of the villagers	-	-	4.4	-
Link between PHC and the village	-	2.8	5.0	1.4
The crowd at the PHC will be reduced	-	-	1.1	-
Villagers will be benefitted	-	-	7.8	-
Unemployment will be reduced	-	-	1.7	-
Supplementing the health care system	-	36.1	-	-
Coordination with PHC	2.2	-	-	-
Referrals are possible	3.1	-	-	-
Good scheme/will promote health services	17.0	-	-	-
Will promote F.W. and distribution of Nirodh	2.9	-	-	-
Treatment of minor ailments	9.1	-	-	-
Prevention of communicable diseases	1.9	-	-	-
Will promote MCH Scheme	1.2	-	-	-
Will provide employment to villagers	0.7	-	-	-
Will create awareness of Hygiene and sanitation	6.5	-	9.4	5.8

@ The percentages do not total upto one hundred as more than one response was given.

N = Total number of respondents in different categories who wanted that the scheme should continue.

NR = Non-response

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APPENDIX IX(b)

PERCENTAGE DISTRIBUTION OF COMMUNITY LEADERS, BDOs AND ZILA PARISHAD PRESIDENTS ACCORDING TO THEIR VIEWS REGARDING BEARING THE EXPENSES OF THE TRAINING OF NEW CHW IN CASE THE CHW DROPS OUT BEFORE HE/SHE COMPLETES THREE YEARS

Opinion about bearing the expenses	Community Leaders N = 604	BDOs N = 73	Zila Parishad Presidents N = 42
Community will not bear	44.4	36.5	53.7
Community will bear	27.0	20.6	17.1
Candidate who got training should bear	7.6	27.0	17.1
Government should pay	8.6	11.1	7.3
New candidate to be trained should bear	0.3	-	-
Government or Panchayat will bear	0.7	1.6	-
Community will bear upto 50% of the expenses	0.6	-	-
No response	10.8	3.2	4.8

N = Total number of respondents in different
categories.

